DOCUMENT RESUME

ED 075 600 VT 019 822

TITLE	Occupational Rehabilitation and Placement of the Disabled.
INSTITUTION	Centre for Information and Documentation of the European Communities (CID), Luxembourg.
PUB DATE	Sep 71
NOTE	519p.; Proceedings of the European Symposium on Occupational Rehabilitation and Placement of the Disabled (Luxembourg, May 24-26, 1971)
EDRS PRICE	MF-$0.65 HC-$19.74
DESCRIPTORS	Job Placement; Medical Services; *Occupational Therapy; *Physically Handicapped; Public Policy; *Rehabilitation Programs; Sheltered Workshops; Symposia; *Vocational Rehabilitation; *Vocational Training Centers
IDENTIFIERS	Europe

ABSTRACT

The proceedings of the European Symposium on Occupational Rehabilitation and Placement of the Disabled present a general survey of the problem of reintegrating disabled persons into working life. Member countries agreed that men and women must be rehabilitated as much as possible rather than pensioned off prematurely. To accomplish this the labor market must be opened to the disabled and kept open. The document includes addresses and discussions on the role of medicine in rehabilitation, occupational rehabilitation and training, job placement and adjustment in normal and protected working conditions, and points of view of the disabled, employers, and others. It was felt essential to find a link between the medical and vocational stages of rehabilitation and to coordinate the complete process so that the disabled may have a chance of success. The material collected at the symposium should assist the members of the Commission of the European Communities to work out on the political level a program to rehabilitate and employ the disabled. Formation of a permanent body of scientific and government experts, employers, workers, and disabled persons was recommended to develop methods and means. (MF)

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COMMISSION OF THE EUROPEAN COMMUNITIES

ED 075600

OCCUPATIONAL REHABILITATION AND PLACEMENT OF THE DISABLED

European Symposium
Luxemburg, 24th–26th May 1971

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COMMISSION OF THE EUROPEAN COMMUNITIES

Proceedings
# of the European Symposium on
OCCUPATIONAL REHABILITATION AND PLACEMENT OF THE DISABLED

Luxemburg, 24th–26th May 1971

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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General Directorate "Social Affairs"

Edited by the Directorate General for "Dissemination of Information"
Centre for Information and Documentation — CID
Luxemburg, September 1971

EUR 4720 d, f, i, n, e

NOTICE

The Commission of the European Communities is not responsible for the use which could be made of the information presented in this document.

REMARK

In preparing the proceedings of the Symposium, the organisers opted for speed in the printing and distribution rather than linguistic perfection in the translations.
The reader is therefore asked to excuse any imperfections he may encounter in the text.

The problem of reintegrating disabled people into working life is one which has many psychological, medical, economic and social aspects. Are resettlement opportunities available to all disabled people? Which of the methods currently practised are most suitable? What cooperation can be organised between the Member Countries and Institutions of the Community in this field?

The European Symposium on Occupational Rehabilitation and Placement of the Disabled has attempted to give an answer to these questions, and these Proceedings which I have the honour of presenting give a general survey of the present state of the problem. It will provide good reference material for doctors, psychologists, economists, politicians and all those who are interested in or contribute to the development of European social policy.

Albert COPPÉ
Member of the Commission responsible
for Social Affairs

This conference was under the patronage of:

Messrs.	W. Arendt	Minister of Labour and Social Affairs, German Federal Republic
	W. Behrendt	President of the European Parliament
	A. Borschette	Member of the Commission of the European Communities
	R. Boulin	French Minister of Public Health and Social Security
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	P. De Paepe	Belgian Minister of Social Welfare
	C. Donat Cattin	Italian Minister of Labour and Social Welfare
	J. Dupong	Minister of Labour and Social Welfare, Luxemburg
Miss	C. Flesch	Burgomaster of the City of Luxemburg
Messrs.	J. Fontanet	French Minister of Labour, Employment and Population
	W.C. Jenks	Director General of the International Labour Organisation
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	J.Regniers	President of the International Society for the Rehabilitation of the Disabled
	B. Roolvink	Netherlands Minister of Social Affairs and Public Health
	L. Toncic-Sorinj	Secretary-General of the Council of Europa
	P. Werner	Minister of State, President of the Luxembourg Government

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INAUGURAL SESSION

Chairman: Mr. A. COPPE
Member of the Commission of the European Communities

- G. GERUNDINI, Member of the Organising Committee

Sir,

In December 1970, you sent an extremely important letter to some fifteen people, doctors and educationalists in the field of rehabilitation, and to trade unionists and politicians. In it you said that:

> The Commission of the European Communities intended to take positive action to encourage the rehabilitation and social reintegration of the disabled and considered that priority should be given to solving the problem of providing the disabled with concrete possibilities of employment, in activities which were both useful and remunerative;
>
> The Commission of the European Communities considered it necessary for there to be an exchange of practical experiences in this field as soon as possible, and for this purpose was organising a European colloquium open to all competent persons interested in this problem;
>
> To prepare for this colloquium, the Commission of the European Communities wished to avail itself of the opinions and cooperation of an organising committee, and the addressees of your letter, Sir, were invited to participate on it.

I believe that I can state that all the addressees replied in the affirmative. The organising committee consequently met in December, February and March, under the chairmanship of Mr. VINCK, the Director General of Social Affairs of the Commission. These three meetings dealt with the critical aspects of rehabilitation, the practical difficulties which would have to be cleared up during the colloquium, the appointment of experts to present the papers, and the catego-

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ries of persons to be informed in order to secure their participation.

The organising committee is happy and proud to have completely accomplished the task entrusted to it: you, Sir, have in your hands a programme; the speakers are present; several hundred people have registered. The work of preparation is over; the "colloquium" can begin.

May I first of all, on behalf of all my colleagues on the organising committee, thank the Commission of the European Communities, you, Sir, and Mr. VINCK, who wished this colloquium to take place and played an important part in its practical organisation, and lastly, the Services of the Commission, which worked so hard to make today's meeting possible.

On behalf of my colleagues, may I also express the wish that this colloquium may really be a point of departure for new action on a Community basis, carried out ~~in~~ an effective manner and with effective methods. It is high time for such action, and not only in the six countries ~~of the Community~~.

In conclusion, I wish to assure you, Sir, that the organising committee which you formed last December will continue during these three days to give its full and unreserved collaboration to you, the colloquium, and the delegates.

- C. FLESCH, Burgomaster of the City of Luxembourg

Mr. Chairman,
Mr. Commissioner,
Ladies and Gentlemen,

On behalf of the City of Luxembourg I extend to you a hearty welcome and thank the Commission of the European Communities and the Organising Committee for organising in our City this European Symposium on occupational rehabilitation and placement of the disabled.

It is always a great pleasure to us to be able to act as host to the Community's meetings, especially when they bring delegates from beyond the frontiers of the Community.

It is certainly not for me to talk about the subject with which you will be concerned, but I must say how happy I am to see so many experts from near and far, gathered here to examine all aspects of the integration of the disabled into our society. I think this is indeed a challenge to our affluent industrial society and I am certain that solutions will emerge from your deliberations which will bring more humanity into our Community, which is sometimes accused of being a technocratic one, though, I would hasten to add, wrongly so, in my opinion.

It only remains for me to hope that your work will show fruitful results, in your own interests to be sure, but in the interests of all of us too. Thank you.

- A. COPPE, Commission of the European Communities

"The disabled in the social policy of the European Communities"

I should like to offer my particularly hearty thanks to Professor GERUNDINI and to all the members of the Organising Committee. It is with great satisfaction that I note the value of the preparatory work which has been done. Thanks to the work of the Committee, thanks also to the cooperation and effective assistance of the departments of several Directorates General, we have succeeded in bringing about this meeting at which, for the first time, I must congratulate all concerned on the result they have achieved in so short a time.

But I would also like to stress the part of Mr. VINCK, Director-General for Social Affairs, in the success of this meeting. Indeed, the personal contribution made by him to its organisation has been extremely effective.

Finally I wish to thank all those who have placed their confidence in us and who have accepted the task of acting as chairman at the sessions, of presenting papers or participating in the discussions, thereby giving us the benefit of their experience.

We sought this meeting. Here we are now face to face. Now is the time to define our objectives.

By accepting our invitation to come to Luxembourg, Ladies and Gentlemen, you have responded to a call from the Commission of the European Communities. Perhaps you follow Community developments, the political and economic significance of which no doubt does not escape you. But it is perhaps more difficult for an observer from outside our institution to be aware of and to follow the activities of the Communities in the social field, activities of which our meeting today will form a part. I ought therefore to give you one or two explanations on this subject.

If you take a little time to read the Treaty of Rome or the Official Gazette of the European Communities, you will no doubt gain the impression that the Common Market is essentially concerned with economic and customs matters. But you will perhaps also remember the fact that the Conference of the heads of state held in The Hague in December 1969 decided that the Common Market should be developed from the custom's union which it had been up to that time to a true economic and monetary union based on the full development of common policies.

These various "policies" are not theoretical ideals, they are a reality: they consist of a body of objectives and means of intervention, which the treaties make available to us, and of a body of rules of implementation and consultative and administrative bodies which enable them to be applied.

The most difficult task in connection with these policies is to reach agreement on the choice of objectives to be pursued, which could really be called "common objectives". But at the same time it has become more and more evident that such objectives cannot be set without taking into account the close-interdependence of social and economic factors.

The redevelopment measures made necessary by the decline of the coal industry and implemented under the terms of the

ECSC-Treaty are an illustration. It was not merely a case of replacing certain industries by others, but also of redeploying 5oo.ooo workers affected by the energy change-over, which constituted one of the most unexpected and most violent upheavals in the recent economic history of Europe.

It is no longer possible today to leave out of account the social aspects of economic development, just as it is no longer possible to leave out of account the economic repercussion of the social measures which are proposed. This is why the establishment of medium-term economic development programmes (we are now in our third) has led us to seek and clarify the correlations which exist between social policy and the other Community policies.

As a natural consequence, the Commission mapped out "preliminary Orientations for a Community social policy". This document, which has been laid before the Council, will be submitted for open discussion to all interested bodies in order to obtain their reactions and opinions and, of course, their assistance in the projects which will finally be given priority within the framework of the European Community: wether the reasons be that they are indispensable to the achievement of economic and monetary union between now and 1980 or that the action becomes several times more effective if it is pursued on a common basis.

Among the various subjects on which the Commission proposes that action should be taken by our Community, aid to the disabled occupies a position of priority.

The treaties, in their present version, already give us the authority to tackle the problem of the disabled through research on the means of securing better employment opportunities for them and also through furthering their vocational and social interests, Put this way, the problem becomes one of the most urgent tasks facing any advanced industrial society. Just as permanent training and retraining are considered to be essential functions in a developed industrial society, rehabilitation and vocational retraining of the disabled and their resettlement are just as much essential functions of our society.

What is the attitude of the European Commission with regard to the problem which concerns us today?

According to reliable estimates, the number of disabled persons in our Community is at present some 12 million, out of a total population of 190 million, or about 15% of the active population.

Our economic growth has attained rates which have never been achieved before. Indeed, with 5,3% per year growth in the GNP during the last few years, we have achieved (excluding Japan) a world record. But it is important to know that our society imposes ever higher standards of efficiency, in order to sustain the intensification of competition, on men who are not necessarily all athletes. With our general increasing prosperity, the lives of the disabled become more difficult. The increase in the number of children who do not manage to follow a normal course of education, at the dawn of their lives, bears witness to this. These problems are on the increase, because industrial society demands more as its economic progress becomes faster, The research for possible solutions is the earnest preoccupation of all those responsible.

Of course, we know how to prevent a large number of disorders. We know how to treat effectively a large number of diseases and traumatic injuries. We are able to bring relief to people suffering from chronic disorders. On the other hand, we understand that technical progress imposes the need to think about vocational training which will suit the needs of adults. Nevertheless, in the case of a particular middle-aged individual who, for medical reasons, has to change his job, we are not always in a position to enable him to make this transition.

We must, as far as possible, retrain men and women rather than send them into retirement. We must throw open the labour market to disabled workers and keep it open to them.

The reason why we have chosen as the central theme for this Symposium occupational rehabilitation and placement is that it seemed essential to find a link between the medical and occupational or, if you prefer, economic phase of rehabilitation. Too often, even today, we can only respond to the uncertainty which plagues a disabled individual by offering limited and short-term prospects. How can we hope that, under these conditions, the person concerned can have sufficient motivation to embark with confidence on the various measures which we suggest to him? An adequate chance of success can only be offered by taking responsibility from the outset for the whole process, so that the individual concerned may be secure in the knowledge that the means to be applied stage by stage will be effectively coordinated and that the course to be completed will lead to a satisfactory conclusion for him. Basically, we should aim at eliminating the distinction between the disabled and the rest by proper integration. This is the ultimate goal. Only when it has been achieved shall we have done away with the impression of dependency which afflicts some of our fellow-men.

I have mentioned in turn: 1. the problem raised by the rise in economic standards of efficiency and in educational prerequisites, and 2. the problem of taking overall responsibility for the process of rehabilitation and resettlement in the interests of consistency and continuity and of giving the disabled subjects the motivation and confidence they need. One final problem remains for me to mention, and that is the immediate utilisation of rehabilitation resources which are available at local level. This implies initiatives in which entire responsibility for the use of resources does not lie with the central authorities. We must make a big effort in the field of training instructors, at numerous locations in the Community, and compare notes and coordinate our experiences in a field as important as this. Without well-trained instructors much of our effort will be in vain. In particular, we shall need rehabilitation advisers and occupational therapists, in a decentralised approach covering the whole Community.

I raise these problems because experience gained in action of limited scope has shown us that these are real difficulties.

The Council of Ministers has asked us to submit proposals concerning the cooperation which could be instituted between our six countries and between the Council and the Commission on the problem of the disabled. We have been able to lay before the Council of Ministers certain proposals for action, and we have outlined the present state of the problem, as it is known to us, in a first study which you will find in your dossiers. This study is of course not exhaustive, but it already throws some light on occupational rehabilitation and placement of disabled workers. In order to guide us in our own action, we felt that it was necessary to compare a sufficient amount of evidence, concrete experiences and methods.

Before opening this meeting, I would like to say again that it is not a congress and it is not a conference. It is not a congress, because our aim is not limited to the presentation of papers. It is to determine a course of action. Nor is it a conference because we have no negotiations to pursue, and no special interests of different categories of people or of different bodies to consider. Our meeting must therefore take the form of a technical exchange, in the widest sense of the term, in which each one informs the other of his own experience and is completely free to express himself as he thinks fit.

How shall we use all these discussions and especially our conclusions? We shall inform the Council of Ministers of them. Indeed we want to work out together with the Council, at a political level, a joint approach to our thinking on the problem of rehabilitation and an approach to the promotion of employment for the disabled, consonant with the objectives of the age in which we live. We want to transcend the orientations and lines of conduct which have governed our progress hitherto. We want to work out new programmes of action.

During recent years, a large number of projects of a specific nature have been completed, some of them extensive in their scope. They are already inadequate and with the alarming increase in the number of road accidents, they will be totally inadequate tomorrow. We must, moreover, meet the need for joint action, as regards the means available in each country and the manner in which they can be used.

Joint action can only be effective in terms of an over-all conception of rehabilitation, which should be extensive enough to cover every aspect and which would be common to all our countries.

Economic progress in general would cease to weigh heavily on some by the individual acceptance of certain social burdens, which are part and parcel of a new function of society, which may, moreover, if it is properly managed, return as much as it costs to society in general.

In the course of these three days, the Commission intends with your help to go further in the field of ideas; it intends in fact to establish the guide-lines of a policy based on a synthesis of concrete experiences. It hopes that you will contribute to this synthesis. The Commission will not fail to develop its action and to reach conclusions with which I hope you will associate yourselves.

At the first meeting of the Permanent Committee on Employment, a consultative body for exchanges between Community institutions and the two sides of industry, the problem of employing handicapped workers was like-wise considered a priority problem.

Moreover, in the reorganisation of the operation of the European Social Fund, it was explicitly provided that the latter should finance local and national action for the benefit of the disabled. Thus it would be possible to envisage pilot projects with a view to avoiding duplication of work and to combining our efforts in the search for appropriate methodologies.

We also have available to us certain research facilities, especially within the ECSC. Moreover, within the framework of the economic and monetary union, it is certain that an increasing degree of coordination will be brought into the working-out of the social budgets of our six countries.

I think that we must welcome these new methods of working, the means they place at our disposal and the responsibilities in which they engage the European Community.

The response to this Symposium and the quality of the personalities gathered here today leave no doubt that your work will be fruitful and will supply the Community institutions with the basic elements which will be indispensable in the launching of a programme of action on a Community scale.

It is in this certainty that I open this Symposium of Occupational Rehabilitation and Placement of the Disabled.

- P. HOUSSA, World Health Organisation

Mr. President,

I have the honour of representing the European Office of the World Health Organisation at this Symposium.

Rehabilitation problems have always been one of WHO's main concerns and I can only congratulate the Commission of the European Communities for the initiative they have taken in this sphere.

The distinguished audience, the quality of the programme and the speakers' high qualifications are a guarantee of the success of this occasion.

Mr. President, on behalf of the European Office I convey you my best wishes and hope that the good results which are bound to come of this work will ensure the rehabilitation of a greater number of disabled persons.

- N. COOPER, International Labour Organisation

Mr. President, Ladies and Gentlemen,

On behalf of the Director General of the International Labour Organisation and all colleagues in Geneva, may I say how pleased and honoured we are to have the opportunity of participating in this important Symposium on Rehabilitation and Placement of the Disabled, organised by the Commission of the European Communities.

As you may know, the International Labour Organisation was founded in 1919 to advance the cause of social justice and it is not surprising therefore that vocational rehabilitation of disabled persons has been of fundamental importance to the ILO since its inception. In fact, the formulation of international guidelines and standards in this field, particularly those embodied in ILO Recommendation 99 concerning vocational rehabilitation of the disabled, has provided the body of principles on which the development of all vocational rehabilitation services can be based.

In addition to undertaking research into general, and specific problems of vocational rehabilitation, disseminating information and organising seminars and training courses, the ILO has an active programme of technical cooperation in developing countries. In the past 15 years such cooperation in the form of experts, fellowships and equipment has been provided to some 60 developing countries of Africa, Asia, Latin America and the Middle East. The nature of the technical cooperation asked for and provided varies widely from country to country depending on the level of social and economic development reached, but may involve the planning and organisation of a national vocational rehabilitation programme for all or specific groups of disabled persons, the establishing of training, rehabilitation and sheltered workshops and the development of selective placement services.

This ambitious programme, however, could not have been undertaken without the closest cooperation and assistance of other international agencies, governments (who have so willingly provided experts, many of whom have been recruited from the European area) and non-governmental organisations with general and specific interest in this field.

In wishing the Symposium every success and assuring the Commission of the ILO's fullest possible cooperation and support for its endeavours in securing acceptance of the disabled as valued and productive members of the Community, may I express the hope that your deliberations will stimulate further professional interest in and public awareness of the vital importance of vocational rehabilitation of the disabled, not only in Europe, but throughout the world.

- O. MESSER, Council of Europe

Mr. Chairman, Ladies and Gentlemen,

By according his personal patronage to this Colloquium, which is taking place in the city that accomodated the first institution of the European Communities, the Secretary General of the Council of Europe wished to demonstrate his keen interest in the subjects on the agenda and the importance that the Council of Europe attaches to the various humanitarian, medical, scientific, technical, social, educational, psychological, economic and administrative aspects of rehabilitation. The Secretary General sends his best wishes for the deserved success of this Colloquium.

First, Mr. Chairman, I should like to thank you for your kind words of welcome and to tell you how pleased I am to have an opportunity to outline to this audience the work done by the Council of Europe in the field of rehabilitation.

The Social Committee of the Council of Europe, on which are represented all the seventeen member States of this organisation, instructed a study group, in the context of the coordinated social research scholarships (1969 programme), to prepare a report on the legislative or other measures taken by member states for the social rehabilitation of physically or mentally handicapped persons. This report, which was drafted in 1970, will be published in the course of the year; in addition, the Social Committee has just set up a Sub-committee whose terms of reference are to prepare conclusions on the main points brought out in this report, such as the need for society to consider and implement measures for the integration of the disabled into working life and into the community in general; the importance of early diagnosis of certain diseases to prevent a possible future disability; education of the public and the training of persons concerned with rehabilitation; and the codification of the principles of the legislation and regulations on rehabilitation. These Conclusions will be published in the form of a Resolution having the force of a regulation for member governments. It is expected that this Resolution will be adopted by the Committee of Ministers of the Council of Europe at the end of 1972.

Another organ of the Council of Europe, the Joint Committee for the Rehabilitation and Re-employment of the Disabled of the Partial Agreement, has been active for twenty-two years. It was originally set up under the Brussels Treaty, signed in March 1948 by Belgium, France, Luxembourg, the Netherlands and the United Kingdom. This Treaty was later modified and supplemented by a Protocol signed in October 1954 by the above-mentioned states and by the Federal Republic of Germany and Italy; in this way the Western European Union was born. In November 1959, the WEU transferred its social and cultural activities to the Council of Europe. During all these institutional changes, the Joint Committee for the Rehabilitation and Re-employment of the Disabled continued its work without a break. Since its transfer to the Council of Europe, it has been operating under a "Partial Agreement" instituted between the seven above-mentioned States within this Organisation; in 1962, Austria joined this Committee.

The work and even the spirit of the Joint Committee have undergone a profound evolution; this body, set up in the post-war years in order to alleviate the serious consequences of the conflict, has extended its activities to cover the rehabilitation of various categories of disabled persons (industrial accident cases, the civilian disabled in general, persons suffering from handicaps due to disease, etc.); the Committee is an important forum for discussion between representatives of national Ministries of Labour and Social Affairs, Public Health, and ex-servicemen with a view to the harmonious co-ordination of national legislations and techniques of medical, functional and occupational rehabilitation.

One of the cardinal principles of the policy recommended by the Joint Committee is the need to consider rehabilitation as a continuous process, starting from the moment the disease is detected or the accident occurs and continuing until the disabled person is finally employed under the best possible living and working conditions. In this context, it is essential, from the start of the disability, to determine the level of the residual faculties so as to be able to decide on the type of work for which the disabled person is best suited and to offer him appropriate career guidance and vocational training. Hence the importance, stressed in the first Recommendation adopted by the Joint Committee, of establishing very close liaison between the various bodies concerned with rehabilitation and re-employment, such as national or regional authorities and charitable organisations and especially between the different groups of medical and other personnel directly concerned with rehabilitation.+

+ Point 13 of the Recommendation on invalid rehabilitation policy (Recommendation I adopted in May 1950 and revised in November 1958 by the Joint Committee).

These general guidelines are given in the form of conclusions to the Report on legislation on the rehabilitation and employment of invalids. This report, which is updated annually, is the most important part of the Committee's work, as it gives a synopsis of the progress of legislation in the states concerned, drawing a distinction between the various classes of disabled persons with regard to their rehabilitation, specifying the measures taken by states to secure employment for them (for example, obliging the public and private sectors to reserve a percentage of jobs for the physically disabled) and describing the institutions existing in the different countries for implementing these measures.

Here I shall merely outline the aspects of the Joint Committee's work that relate to the reintegration of the physically disabled in society and at work.

The Committee is now revising two Recommendations it adopted some years ago relating to individual transport facilities for amputees and paraplegics and to the adaptation of public buildings to facilitate access for the physically disabled.

The latter instrument recommends, amongst other things, state intervention to secure the co-operation of the trade unions for the building construction industry, in both the public and private sectors; it not only deals with the architectural aspect of the buildings - special accomodation on the ground floor, staircases, etc. - but also sets forth town planning principles - for example, the concentration of shops, and the layout of parks and open spaces. The revised text of this Recommendation should be sent out to faculties of architecture and town planning colleges and also to technical colleges for the building trade.

The first Recommendation covers the provision of folding and non-folding wheelchairs, invalid carriages with and without engines, cars specially adapted for amputees and paraplegics and the issue of an internationally valid driving licence. In the latter context, the Committee is awaiting the results of the work of the Economic Commission for Europe's working group on traffic safety, which, in co-operation with experts from the World Health Organisation, has drafted a resolution on the harmonisation of possible criteria for determination of driver ability.

These two questions should be considered in conjunction with other similar problems also being studied by the Committee, such as the measures to be taken to facilitate access to and use of means of transport by the disabled.

All the above must obviously be considered in accordance with the possibilities - direct or indirect - available to the disabled for reintegration in the working world by special adaptation of their environment, including their means of locomotion.

The Joint Committee has studied the problem of defining the concept of "disability" in relation to employment: its approach was pragmatic, trying to derive general principles from an analysis of the current legislative systems: for example, by comparing the various national provisions on the conditions to be satisfied for qualification as a "disabled worker" and by establishing that, even if the disability is necessarily expressed in relation to the specific former occupation, other and more positive criteria should also be taken into consideration, such as an assessment of residual working capacity and the willingness of the physically disabled person to co-operate in his reintegration into employment.

This latter factor - essentially a psychological one - also plays a very important role during the process of training to exert effort and pre-vocational re-education, a transitional stage between medical/functional rehabilitation and the return to work. At its next meeting - planned for

June of this year - the Committee will examine notes prepared by the different delegations which illustrate the ideas and practices prevailing in this field at national level.

With a view to the adoption of joint measures, the Committee will also make a detailed study of the possibilities of adapting work places by applying ergonomic principles to the particular case of the disabled, in order to enable them to become integrated in the working of a firm as a whole. This consists of adapting the job to the retained or recovered faculties of the worker; for example, the adaptation of telephone switchboards so that they can be operated by blind persons.

At its next meeting, the Committee will complete a "lexicon of rehabilitation and resettlement" which defines terms such as "invalid", "rehabilitation" (medical, functional and psychological) "occupational profile", "vocational guidance", "vocational training or re-education" and "sheltered employment".

The Committee a few years ago also adopted a Recommendation on sheltered employment. In addition, a very large number of reports and recommendations from this Committee, adopted by the Committee of Ministers of the Council of Europe, limited to representatives of the member states of the Joint Committee, deals with the medical rehabilitation of several categories of physically disabled persons.

The complete documentation is listed in an appendix to my paper.

Finally, I should like to thank you for giving me your attention.

Thank you, Mr. Chairman.

- **A. DASSBACH**, International Association for Social Security

Mr. Chairman, Ladies and Gentlemen,

The Secretary General of the International Association for Social Security, Dr. Leo **WILDMANN**, has asked me to thank the Commission for its invitation to this symposium, and to express his regret at being unable to be present here today.

The International Association for Social Security was founded in 1927, and operates as an agency of the International Labour Organisation, its staff being appointed by International Labour Office. Though the Association's head office is housed in the International Labour Office, it forms an entirely separate organisation with its own administrative network and organs. At present there are affiliated to it 270 institutions and establishments from 47 countries, representing altogether 500 million members of social security schemes.

Many of the Association's member institutions concern themselves - either voluntarily or as a statutory obligation - with problems of rehabilitation. Many have their own rehabilitation centres; others subsidise such centres or collaborate with rehabilitation services of various kinds.

The results of this symposium and the work of the Community are accordingly of keen interest to the Association and its members.

In turn, the Association is prepared to place the results of its own past, present and future efforts in the field of rehabilitation at the disposal of the Community.

Its first studies on various aspects of rehabilitation were carried out by the International Association for Social Security through its standing committee for social medicine, and resulted in the following reports:

1. How to measure disablement;

2. The effect of occupational rehabilitation on standards of performance;
3. Standardisation of criteria of fitness for work;
4. Survey of social security measures and services to assist rehabilitation.

All these reports were based on international questionnaire surveys among the Association's member institutions.

Another survey currently being conducted on "Existing social security arrangements for assisting rehabilitation" has so far elicited 50 replies from 43 countries.

A long-term programme of the Association's future activities was presented to its executive committee by the Association's study group on rehabilitation, of which I am a member, at its 17th annual general meeting in September last year. This envisages the following activities:

1. Correlation and evaluation of data collected by the secretariat of the Association regarding the role and activities of the members of the Association in the field of rehabilitation;
2. A survey of all rehabilitation centres operated and financed by member institutions of the Association either themselves or jointly with others, including relevant data with particular reference to the work of various services;
3. Monitoring, analysis, dissemination and exchange of information dealing with rehabilitation;
4. Organisation ofsymposia and seminars on general, regional and specific rehabilitation problems;
5. Commissioning of investigations and surveys on specific rehabilitation problems to be carried out by groups of experts or individual experts;
6. Liaison between the various rehabilitation services

provided by the members of the Association and between the persons administering those services; exchange of guest specialists among rehabilitation centres;

7. Supplying the names of consultants, where this seems desirable or is desired;
8. Working out methods and programmes of educating insured persons and the public about the problems and importance of rehabilitation (e.g. by collecting and disseminating information on centres and activities which are a model of their kind);
9. Proposing and arranging exchanges of social workers, particularly among countries employing foreign workers, both in the interest of better understanding and to improve the rehabilitation of foreign workers, particularly with a view to ensuring that they are able to continue their rehabilitation without a break on returning to their country of origin;
10. Surveys on links between prevention of unfitness for work and rehabilitation;
11. Preparation and exchange of training and information programmes;
12. Promotion and exchange of research in the field of rehabilitation.

All these projects will be supervised, assessed and planned in detail by the study group jointly with the secretariat of the Association. For a start, the study group itself will tackle the following questions and problems:

1. Suitable methods of improving the effectiveness of rehabilitation measures in countries where medical, occupational and social rehabilitation of disabled persons is practised only to a limited extent, if at all;

2. The effect on rehabilitation of technological development;
3. Social insurance protection afforded to persons who have been disabled from childhood;
4. How to measure disablement due to causes other than industrial accidents.

Mr. Chairman, Ladies and Gentlemen,

The speeches of welcome to which we have listened have given us much interesting information on the existing activities and aims of major international organisations. I should like, with your permission, to suggest that, in order to avoid duplication and unnecessary expense, we should explore ways and methods by which the work of the various organisations can be co-ordinated.

I hope that, by telling you about the existing activities and aims of the International Association for Social Security, I will have made some contribution towards this end.

- **P.J. TREVETHAN**, International Society for Rehabilitation of the Disabled

Mr. President,
Members of the Commission,
Participants in the Symposium,
Honoured Guests,
Ladies and Gentlemen,

I am distinctly honoured in the privilege you have given to me to bring you warm greetings and cordial good wishes for the success of this meeting.

These greetings are from myself personally, from the Vocational Commission of Rehabilitation International with whom you have been working to organise this Symposium and

and from Monsieur le Président Jean REGNIER, whose commitment and purpose is to use the disciplines of Vocational Rehabilitation as an instrumentality for assisting in the cause of world peace and as an expression of concern for the handicapped and disabled people of this world, who are our brothers.

It is especially significant that in arranging this Symposium the organisers recognised, and in the foreword of the programme gave expression, for the need of a common approach to a universal need, namely that of giving to the disabled the opportunity to fulfil to their highest capacity the potential they hold to become useful, recognised and accepted citizens of the new brave ideology we call One World.

It is not necessary for me to suggest that this era in which you and I are living is at one and the same time a terribly complex and challenging civilization. In the olden days there was given to our fore-fathers an escape mechanism from the difficulties of their day. They could discover new lands, they could pack up their belongings, collect their families and move to new and unsettled areas where they began life anew according to the dictates of their wishes and choice. The pressures of unwanted philosophies were no longer present. The task of caring for the disabled and handicapped were left with those who remained behind, for they were the strong and the powerful.

Today, relatively speaking, there are no new lands to which you and I can escape. Distances have been annihilated. Communications have become instant and what happened in Viet Nam, Moscow, Washington or Luxembourg last night is with us this morning. We cannot ignore or run away from the demanding responsibilities that have been cast upon us for the care of our handicapped and disabled fellow-men.

Facing the inevitabilities of this situation, the organisers of this Symposium decided to do something about meeting this present problem. They saw a common factor of universal need in the countries they represented and recognised the values which are always present when we seek to work together. A rugged ragged individualism was to be no longer accepted. The world community needs of our fellowmen became dominant. Only in community cooperative action as envisioned in the interest and concern of the sponsors of this Symposium do we find an adequate resource for meeting one of the most demanding, as well as one of the most rewarding challenges of the seventies.

The historian Toynbee, when writing about his concept of what will be remembered when the period of time in which you and I are privileged to live, is recorded, said: "this period of the world's history will be remembered not for its arms or navies, not for its guns and military aircraft, not for its conflicts of misunderstanding, hatred and injustice, important as all of these are from a temporary viewpoint. Rather", said the historian, " this period of history will be recorded and noted as the first time in all history when man becomes concerned about the welfare of his fellow-men".

In the achievement of this greatly to be desired goal, we who are here assembled this morning commit our thoughts, our experience, our dedication and our service to the welfare of others.

The Vocational Commission of Rehabilitation International and its parent organisation salute the organisers and sponsors from the Commission of the European Communities and extends to all participants the earnest and sincere wish that the sessions in which we are about to engage will be stimulating and fruitful.

May our coming together and the sharing which we will do in Luxembourg, in the words of the astronaut upon his arrival on the surface of the moon, be one giant step in the cause of peace and world brotherhood. May it herald the coming and development of a brighter and more hopeful day for the disabled everywhere.

To this task the Vocational Commission of Rehabilitation International pledges its support and unites with you in every good effort which shall be put forth today and all the todays which are a part of our tomorrow.

To this end so may it be.

- **F. VINCK**, Commission of the European Communities

On behalf of the Commission of the European Communities I have the privilege and pleasure of extending my warmest thanks to the international organisations which have done us honour of being represented among us today, the International Labour Organisation, the International Society for the Rehabilitation of the Disabled and the Council of Europe.

Thanks to their presence here and the help they have given us in its preparation, the echoes of this Symposium will be heard beyond the frontiers of the Community, thus demonstrating that in this field, as in all others, the Community is an open one.

With regard to the problem which concerns us here, it is important that we should exchange our knowledge with each other. The Commission of the European Communities makes no claim to have discovered the problem of the rehabilitation of the disabled, but it wishes to translate this idea into practical terms. We need the help of our predecessors in this field. There cannot be too many of us tackling such an extremely complex and difficult task.

This is why once again, on behalf of the Commission of the European Communities, I should like to express my gratitude to the international organisations represented among us today.

- **U. VIDALI**, Commission of the European Communities

Ladies and gentlemen,

Looking around this gathering and seeing how many highly competent people have responded to our invitation, we already feel amply recompensed for all our work in preparing this Symposium. Your presence here confirms our belief that, in organising this occasion, we have met a real need which was not only felt in the Institutions.

Now this opportunity to express our views and to compare notes must not be wasted. We must therefore reach agreement first of all on a few practical aspects of the work that awaits us for the next few days: the "meeting" aspect, the "programme" aspect and the "method" aspect.

A. The "meeting" aspect

We are here to communicate. So let us know who you are. The document case given to you on your arrival contains a badge with your name on it. Please pin it to your buttonhole. You will also find a list of delegates. Please check that your name and address are correctly given and inform the Secretariat of any mistakes. Otherwise, you might not get your copy of the Symposium proceedings.

Glancing through the list, one cannot help but notice the range of difference in starting points, competence and specialisation. This rich variety is a guarantee of the success of our meeting, the aim of which in the most general sense is to pave the way for exchanges. These exchanges concern individual attitudes, common concepts and the language we use.

As good rehabilitationists, you have acquired the habit of contacts and the art of teamwork. Don't forget, today and tomorrow, to put these skills to good use in establishing bonds and building bridges.

What I am more concerned with is the getting around as quickly as possible to using common concepts, by attaching the same significance to them.

Commissioner COPPE has mentioned a document which has been distributed amongst you and which constitues a first study of the Commission on rehabilitation. This report is provisional and not yet complete, and it does not deal in depth with the problems we have to discuss at this meeting. Nevertheless certain basic concepts will be found in this document, in particular on pages 2, 3, 4, 5, and we suggest that you adopt these as provisional references. Until we have worked out common definitions, they will help us to understand one another.

I suggest therefore that we should take the term "handicap" as meaning the discrepancy which exists between the performance expected of an individual and the performance of which that individual is actually capable. If we stick to this definition, we shall not confuse "handicap" with the injury or defect, organic or otherwise, which produces it. In the same way we shall endeavour not to confuse the terms "disabled" or "handicapped" person and "invalid".

In some countries, the law attributes to them a precise meaning. The two following statements will demonstrate more clearly the distinctions I have in mind:

> The concept of "invalidity" suggests pensions, annuities, compensation.
>
> The concept of a "handicapped person" suggests functional compensation, rehabilitation, mutual assistance.

This will help us to avoid misunderstandings, at least when we are speaking the same language.

Passing from one language to another, the difficulties become greater. In the absence of a really satisfactory table of linguistic equivalents, we have made attempts at devising one, and in sodoing have realised the immense difficulty of such an undertaking. For example, the term "disabled person" has no exact equivalent in Italian. We have therefore agreed to use "minorato" in the programme, in order to put across the idea of diminished functional capacity, but it is partly satisfactory. However, the table of equivalents is primarily intended for the translators and interpreters whom we have working with us and for the polyglots among you. Should you be dissatisfied with any of the proposed equivalents, please let us have a copy with your corrections and comments. This will enable us, after the Symposium, to improve it.

B. I turn now to the "programme" aspect.

Most of you, in the course of your particular work, see problems of rehabilitation in terms of the start: the occurrence of an injury, immediate therapeutic measures, functional rehabilitation, etc. If that is the case, we invite you, ladies and gentlemen, to look at the problem from the other end of the telescope, i.e. to think of the whole process of rehabilitation in terms of its ultimate objective, to consider it as a preparation for the time when the disabled person will cease to depend on others for the performance of his every day activities and is again able to take a paid job.

The consequence of reversing the image in this way is that we shall restrict our approach:

a) to subjects of working age; this does not mean excluding the preparation of the disabled person for his first job, but that in this instance we shall not be dealing with the problem of persons suffering from congenital handicaps or handicaps acquired in early childhood;

b) to the major qualitative aspects of rehabilitation, which are common to all handicaps.
The more specific aspects which are peculiar to the individual forms of disablement, will not be dealt with.

As you see, we have adopted a selective approach which seems appropriate for this first meeting. This does not, of course, mean that we are not aware of all the other aspects of the problem of disabled persons.

One of the major aspects of rehabilitation, which is of particular interest to us, is that highlighted by Mr. COPPE: the necessary link between the medical and occupational phase of rehabilitation, as part of a comprehensive and properly coordinated process of rehabilitation. In order to secure an effective presentation of concepts, experiences and immediate needs, we felt it necessary to proceed on two levels:

1. to consider first of all the medical and pedagogical aspects of rehabilitation, intended as a preparation for employment, then the legal and practical aspects of resettlement, in this case from the technical point of view;
2. to place the same problems into a political context and to consider them from the point of view of trade unions and employers' organisations and of disabled persons' associations.

We shall undertake a critical analysis and a comprehensive survey at the final round-table discussion, which I shall talk about in a few moments.

You no doubt have your programme. You will see that it lists papers to be presented on the subjects I have just touched upon. In the majority of cases we shall not be able to supply you with the texts of papers during the Symposium itself.

To compensate for this:

a) We have endeavoured to provide an outline of each paper in the various languages. This will enable you to follow the speakers more easily. You will note that each paper in the programme has a number. The outlines of the papers have been given the same numbers, to assist you in locating them. The outlines which are missing in your collection will be supplied as and when they are ready, and you will find them on the table at the door.

b) Finally, we have undertaken, with the cooperation of our information dissemination staff, who are the experts in the matter, to make sure that the proceedings of the Symposium appear at the earliest possible date, at the latest by automn.

If you have read the programme, you will have noticed that no session has been set aside for the presentation of individual contributions. I know we had asked you to inform us of any special field in which you would be able to make an original contribution. In the course of contacts made on an individual basis, some months ago, we also asked you on what subject you would be able to speak.

However, as our preparations advanced, we realised the importance of drawing the attention of all delegates to certain subjects of a general nature, and we decided that only these subjects should be dealt with by papers. Your contribution must therefore take their place in the discussion; they must be short and to the point. And this brings us to the "method" aspect, which concerns two problems: the discussions and the round table.

We have drawn up the programme with the firm intention of saving as much time as possible for exchanges of views, which will clearly oblige us to limit speaking times. The session chairmen will perhaps have some difficulty in conducting discussions between people who have not met before and in keeping them to order, but I am sure that with your cooperation and indulgence, all will be well. To ensure that this is so:

a) Those wishing to speak are asked to request the floor during the presentation of the papers, without waiting until the discussion opens, and to use the forms provided for the purpose: these will be collected by one of the hostesses;

b) when giving the floor, the session chairman will call out the names of those wishing to speak and will specify the time allowed (from 1 to 3 minutes);

c) when they have the floor, speakers are requested to give their name and place of origin, and then present their ideas in the short time allotted;

d) you are asked to speak slowly and clearly, so that your ideas can be translated correctly into the other languages;

e) when you have spoken, you are asked to write down what you said and to hand it in to the Special Secretariat, or alternatively to dictate it to one of the secretaries, whose services are available to you in a room set aside for the purpose;

f) at the end of the discussion, speakers who have presented papers listed in the programme will only reply to questions requesting clarification of points arising from their papers; other contributions will be regarded as accounts of personal experience and will be included in the general closing survey.

Let us now turn to the final round table discussion. It should enable us to pick out from the body of information supplied by the papers and discussions those items which are of crucial value and which should feature in our conclusions. This why, in fact, we shall begin preparing the round table discussion right at the start of the Symposium.

To this end, Messrs. HOUSSA, HOFRICHTER, VELDKAMP, the rapporteurs for the three main sections of the programme, must have first have available all the important data. Some of this has already been placed at their disposal (conclusions of papers prepared by the authors); the rest will energe during the course of the discussions; finally, you will be free to pass on your ideas in the form of brief notes worked out from exchanges of views in small groups, or to clarify some point which was not properly defined in the discussion. The Secretariat is at your disposal for liaison purposes and to act, if necessary, as intermediaries.

The meeting is now adjourned. This afternoon's session will begin at 2.30 p.m., before the time announced in the programme.

Before finishing, I should like, for my part, to say a special word of thanks to the members of the Organising Committee, the Session Chairmen and all those highly competent people who have agreed to present papers at this Symposium.

PREPARATION OF THE DISABLED FOR PLACEMENT

FROM THE CONCEPT OF TOTAL DISABLEMENT TO THAT OF A HANDICAP

Chairman: M. DERATTE

Président de la Commission d'Avis de l'Office
des Travailleurs Handicapés
Ministère du Travail et de la Sécurité Sociale
Luxembourg

Authors: K.A.JOCHHEIM, R.NOESEN

REPORTS

Dr. NOESEN

By way of introduction, my paper will enumerate and define one or two traditional and modern basic concepts, review briefly the development which has occurred over a hundred years with regard to material compensation and preparation for employment, compare the concept of total disablement and that of a handicap, and extract from this comparative study a common denominator applicable to the conceptions obtaining in our countries.

The result will be rather too schematic, but I hope you will forgive me for this.

Let us, to begin with, make the distinction between individuals suffering from total disability and those suffering merely from a handicap.

1. Material and economic compensation: invalidity. Victims of war and industrial accidents.

1.1. Origin and basic concepts.

The terms "invalid" and "invalidity" are used in everyday language. Initially persons who were wounded or suffered damage to their health in wartime were considered invalids. The term invalidity came to denote both the condition of the person concerned and the pension granted to him - to some extent as a favour, in a spirit of charity or recognition.

The industrial revolution made accidents at the place of work far more common. The German Reich then established a system of social insurance, including accident insurance as one of its main features, to enable responsibility to be shared collectively.

Since then, the victims of industrial accidents have been entitled to social security benefits, in particular a pension for permanent partial invalidity.

Germany's example was soon followed by Austria and, shortly after 1900, by Luxembourg too. It took another fifty years for the social security system to be extended to other countries and categories of workers. It was coordinated in France in 1946; this marked the end of a phase and also the beginning of reforms. In some countries, centralization and coordination are ensured by transferring responsibility for the management of social insurance schemes to establishments such as the F.N.A.M.I in Belgium or the I.N.A.I.L. in Italy.

We shall not examine the new Netherlands legislation which is not so much a development of the existing social security system as a complete recasting of the arrangements; it amounts in fact to a revolution in the basic concepts.

1.2. Permanent partial invalidity; how it is evaluated.

Compensation after an accident originally consisted for the most part in making good material loss. The award of a pension for partial invalidity, especially when the invalidity was permanent, was intended to make good the loss of earnings or more precisely the reduction in earning capacity. The examining doctor or expert was required to report on anatomical (and functional) damage; he had to give his verdict on the resulting reduction in working potential, with reference to standard schedules (usually intended as a guide). The pension committee or other competent authority then had to calculate the exact reduction in earning capacity, in the light of non-medical factors.

The benefits which the pension entailed were designed to enable the invalid to recover, at least partially, his working capacity and provide for his subsistence. The compensation had an economic aim and was based on self-interest. It was hoped that the invalid would return to work - in other words that his working capacity would be recovered as a commercial value.

Finally light "invalid" jobs were reserved for the victims of war and industrial accidents who could not make a recovery.

1.3. The professional factor and personalized compensation.

In general, the invalid receives his permanent, partial pension in addition to his new earnings which are assumed to be lower than his original income.

These original considerations have for a long time been distorted by other factors. New criteria in addition to guide line rates have been written into legal texts and regulations. Some allowance has had to be made for professional knowledge and skills. Because spcialization and qualifications made reference to given jobs on the general labour market meaningless, some countries introduced a supplementary vocational index. The 1946 law coordinating the French social security system, already laid down more complex criteria for evaluation taking into account the nature of the infirmity, the victim's general condition, age, physical and mental faculties, aptitudes and professional skills; the guiding schedule was relegated to the last place. This evaluation makes allowance both for physical incapacity and inability to earn a living, but neither factor takes precedence over the other.

The notion of "two thirds" incapacity has now been backed up by that of "fifty per cent" invalidity, first in connexion with office staff and then with reference to the inability of manual workers to pursue their occupation (Federal Republic of Germany).

A new field of application of retraining measures will therefore be opened to persons seeking part-time employment or a job which gives fifty per cent of their original income.

The number of persons benefiting from social insurance has risen steadily. Under some systems, vocational reeducation or retraining has even become compulsory.

A process of extension and diversification of the social security system is therefore under way today. The basic concepts of compensation which used to be a common denominator, may well be overriden by proposed amendments or reform. This disparity between the regulations is arising at the very time when international or supernational bodies, in particular the Commission of the European Communities, are working towards harmonisation in this sphere.

Two possibilities were open for reforms relating to the needs of reeducation or vocational retraining:

- either to reform the social security system (e.g. by fixing permanent partial invalidity after retraining, as is the case in the Federal Republic of Germany) and extend measures of reeducation or vocational retraining to other persons who are not covered by the normal social security system (e.g. legal provisions and regulations on assistance or social solidarity), or else

- to create something entirely new, i.e. special legislation setting up an employment and resettlement organization not only for victims of war and industrial accidents but for all disabled persons, irrespective of the origin of their disability.

We shall now discuss this second possibility.

2. Human compensation; disability (handicap) and preparation for reemployment. Handicapped persons

2.1. Origin and basic concepts

The terms "handicapped person" and "handicap" (which will be found in most dictionaries) have recently come into current use in the retraining sphere, except in the German speaking countries where a more general expression (Behinderung) which implies impairment is given preference over the literal translation "Handikap". The notion of a handicap was originally confined to horse racing where it denoted the addition of weight to give horses and their jockeys more even chances in a race. In the sphere of retraining, the chances of success can only be balanced if the gap is closed between the performance expected of a person in a specific job or social function (expectations) and the performance he is able to give under the effective conditions of activity (constraints). It is therefore possible to speak of a professional and social handicap, without regard to the specific causes of that handicap.

A handicapped person must be able to benefit from certain advantages, assistance and special measures if he is to have equal prospects of success in his school, professional and social and family life. These benefits are not granted as compensation for anatomical lesions, but as preparation for specific and adequate tasks involving precise functional performance. These measures are finalized instead of causal.

2.2. Evaluation of the handicap

Functional reeducation and vocational retraining are above all a matter of method and technique. Nevertheless the discipline on which retraining is based must be reflected in the legal texts and regulations for practical application.

How can the legislators be persuaded to break new ground?

It was evidently necessary to reconcile the desire to create something new with the attitudes of those who defend firmly established traditions. By a fortunate chance the law setting up an employment and vocational retraining Office in Luxembourg (law of 28 April 1959) already replaced the term "earning capacity" by ability to work as the sole reference notion. Any person whose ability to work is cut by at least 30% is entitled to recognition as a disabled or handicapped worker - but not as an invalid.

It is interesting to note that French legislation on the employment and resettlement of handicapped workers (law of 23 November 1957 does not stipulate a minimum percentage whereas the Belgian law setting up a fund for retraining and social resettlement of handicapped persons (law of 28 April 1958) lays down a minimum percentage of 30% for physically handicapped and 20% for mentally handicapped individuals.

In Luxembourg the legislators did not stipulate the reference against which the 30% reduction in ability to work should be measured. No standard for comparison or reference system was laid down. Are we concerned with a statistical average or a variation in relation to the individual's own condition? To solve this problem, a working party was set up to work out criteria for evaluating disability. It was decided that the reduction of at least 30% in working ability should relate not to the general labour market (in a given region), but to the prior professional activities of the person concerned (Grand-Ducal Order of 30 June 1961).

This figure of 30% is not an absolute value and above all has nothing in common with evalutation schedules. It is intended to indicate the limit beyond which an individual is held to be unable to take care of his own vocational retraining.

Unlike the evaluation of the degree of invalidity on a more or less outright basis for social security purposes, a disability must be evaluated in purely individual terms. An overall approach must be used in order to evaluate the individual working potential by comparing the present situation with the situation as it was before the event which caused the disability.

The evaluation of a disability is not concerned solely with damage and loss suffered; it is also necessary to appraise the remaining capability and aptitude.

A scaffolding erector, fitter, carpenter or roofing worker who has suffered - according to the decision of the accident insurance organization - a reduction in earning capacity or permanent, partial invalidity of 7 to 12% by reason of post-traumatic chleo-vestibular disorders, may apply for classification as a handicapped worker; he will indicate in his application a reduction of his working ability of at least 30% by comparison with his previous professional activities which he must now abandon. It goes without saying that the guidance committee will decide in favour of this person enjoying the benefits laid down by law with a view to his resettlement.

By contrast with the regular routine medical examination or the examination for accident insurance purposes, the handicap will be evaluated progressively in a detailed and personalized manner, in particular by a comparative study of the different reports.

In the case of workers, these reports fall into place between the medical examination of aptitude for employment (where specified) which is intended to reveal contra-indications for certain sectors of activity, and the industrial health examination on employment or when returning to work. An ergonometric analysis of the cycles in the working process will facilitate the task of matching the disabled individual and the place or environment of work.

Reeducation and retraining involve the following main studies:

- examination by the retraining doctor (and not by a single specialist);
- the kinesitherapeutic report covering morphostatic, articular, muscular, sensory and psycho-motor functions;
- the report on capability and performance, based on effort tests;
- the overall report on functions and movements;
- the report on movements in ergotherapy (non-vocational) and in ergopropedeutics (vocational);
- the psychological and psychometric report.

If everyone concerned is in general agreement on these views, it would still be necessary - having regard to the diversity and multiplicity of the methods of investigation - to harmonize the basic concepts and methods of work to some extent; it may even be desirable to prepare reference and codification systems for computer processing.

The evaluation of a disability is not an end in itself but is carried out to allow finalized action to be taken as a preparation for reemployment. It will lead to a decision on assistance and measures of reeducation and retraining of a medical, vocational, social and family and administrative nature.

2.3. Preparation for reemployment.

Legal provisions cover e.g. initiation to work or vocational propedeutics and even vocational training, especially of an accelerated kind for adults; the provision of standard tools or equipment and the supply of specialized equipment; priority for employment and the reservation of jobs for handicapped individuals on the basis of percentage which vary as a function of the country, region or time.

From the legislative standpoint, the last of the above requirements is vital. It means that companies must no longer make jobs available at the employer's discretion but on the basis of a compulsory mutual agreement between the employer and the employment or resettlement Office. In this way a bridge is established to facilitate the transition from the special retraining environment to the working environment in the company, because the benefits laid down by law avoid the difficulties which are so frequently encountered in the search for employment.

After retraining, the disabled worker must be considered as a fully qualified worker in his own right.

3. Invalidity as a static notion. Disability as a dynamic concept.

The concept of invalidity in social security systems is based on the reduction in earning capacity. In recent decades reforms have been introduced which make for more personalized compensation (instead of outright compensation) taking the professional factor more fully into account. Reeducation and retraining have therefore become matters of prime concern.

In some countries special legislation has been enacted covering handicapped persons or workers, regardless of the causes of their handicap. Special bodies have been set up to take care of the employment or resettlement of handicapped persons.

The concept of disability is based on the reduction in the individual's working potential in relation to specific professional activities.

Instead of compensation as a means of making good the loss of earnings, modern methods are concerned with preparation for reemployment, automatically ensuring a suitable or even higher level of earnings. This is the purpose of resettlement.

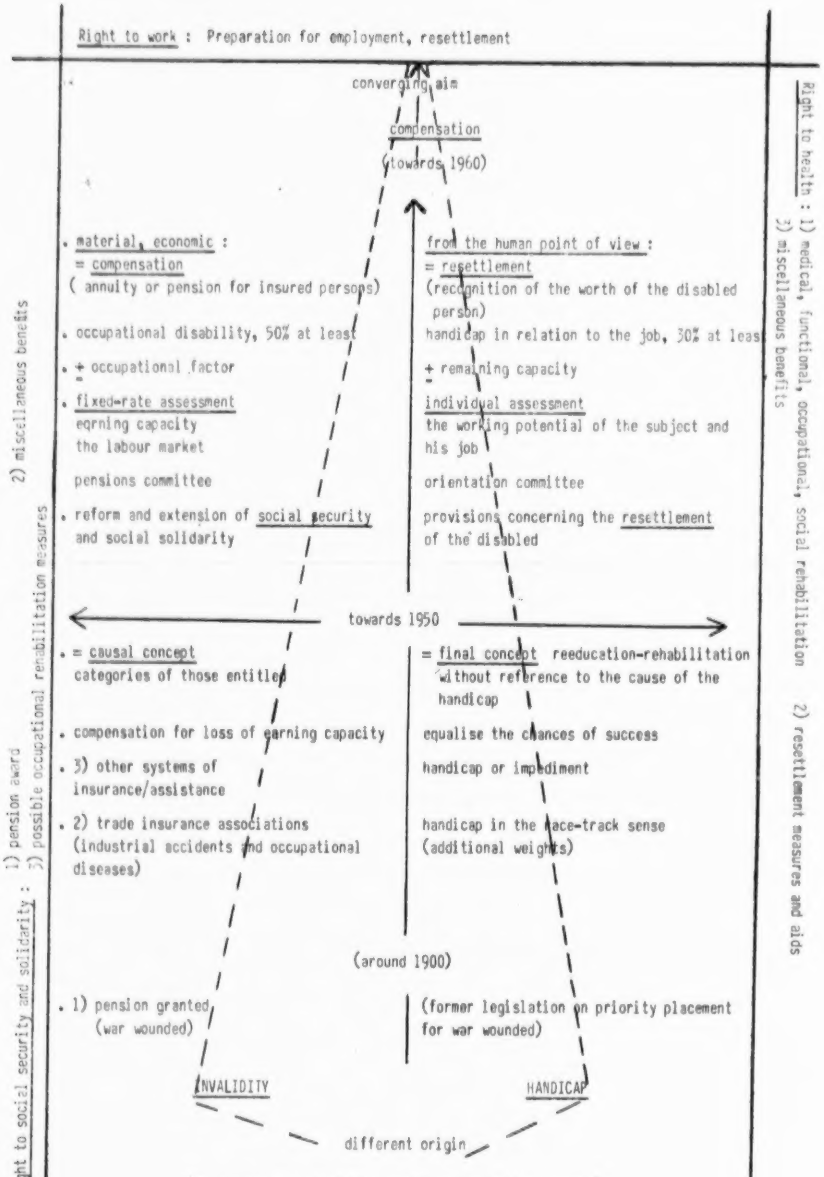
In some countries recognition of an individual as a handicapped worker is linked to a minimum percentage reduction in working ability.

Whereas permanent, partial invalidity generally implied a notion of consolidation and therefore had a static, immutable nature, the handicap or disability is considered to diminish or disappear altogether as a result of retraining and reeducation and therefore implies a functional, dynamic notion which varies with the post occupied.

The more personalized approach for social security and resettlement purposes is leading to a convergence of the concepts, thus facilitating reemployment.

Disabled persons are now entitled to health and employment and, if necessary, to social security or assistance.

(See next page: comparative diagram or ideogram).


Right to work : Preparation for employment, resettlement
converging aim
compensation
(towards 1960)
. material, economic :
= compensation
(annuity or pension for insured persons)
. occupational disability, 50% at least
. ± occupational factor
. fixed-rate assessment
eqrning capacity
the labour market
pensions committee
. reform and extension of social security
and social solidarity
from the human point of view :
= resettlement
(recognition of the worth of the disabled
person)
handicap in relation to the job, 30% at least
± remaining capacity
individual assessment
the working potential of the subject and
his job
orientation committee
provisions concerning the resettlement
of the disabled
towards 1950
. = causal concept
categories of those entitled
. compensation for loss of earning capacity
. 3) other systems of
insurance/assistance
. 2) trade insurance associations
(industrial accidents and occupational
diseases)
= final concept reeducation-rehabilitation
without reference to the cause of the
handicap
equalise the chances of success
handicap or impediment
handicap in the race-track sense
(additional weights)
(around 1900)
. 1) pension granted
(war wounded)
(former legislation on priority placement
for war wounded)
INVALIDITY
HANDICAP
different origin
Right to social security and solidarity : 1) pension award
2) miscellaneous benefits
3) possible occupational rehabilitation measures
Right to health : 1) medical, functional, occupational, social rehabilitation
2) resettlement measures and aids
3) miscellaneous benefits

(the paragraphs should be read from the bottom upwards)

Prof. JOCHHEIM

The social policy demands, the practical realisation of which concerns us in this Symposium, were already embodied in the French constitution of 24th June 1793. Article 21 says specifically: "Public assistance is a holy debt. Society owes its unfortunate citizens their livelihood either by providing them with work, or by granting the means of subsistence to those incapable of working".

The industrialised countries of the world have come nearer to satisfying this demand in the 19th and 20th centuries albeit in small stages, but it was not until after the second world war that the scientific, organisational and social-legal apparatus of rehabilitation was developed sufficiently extensively to meet both demands, namely the claim of each individual to employment consonant with his abilities and to security of his livelihood. The social policy difficulties lay mainly in the fact that, to begin with, on grounds of legal liability, only the group of victims of war wounds and industrial injuries were granted rehabilitation aid and monetary compensation, whilst, in respect of other types of illnesses and injuries, either mediation assistance or pension benefits were provided.

The medical convention, in accordance with which the level of monetary compensation for war and industrial injuries was fixed, was graduated according to medical findings and bore little relation, having regard to the multiplicity of job profiles and varying ways in which the disabled individual could be personally compensated, to the reduction of the subject's occupational potential. This rule has to be strictly adhered to, although the basis of assessment, for example in the Federal Republic of Germany, is termed "Reduction of earning capacity". But it is obvious that the loss of the right leg, which is classed as a reduction of 80% in earning capacity, has very varied effects on occupational income, depending on the previous occupation and the possibilities of retraining the individual concerned. Legislation on pensions for workers and salaried employees retained similar abstract percentages up to 1957, thus forcing the assessment officer to classify the case to a considerable extent without reference to favourable or unfavourable factors and regional employment possibilities.

Abstract classification of this kind, irrespective of wether pensions were granted in respect of a 66 2/3% loss of earning capacity or later as low as 50%, makes for injustice in both directions. A number of disabled persons already receive or still receive pensions, although their working potential is fully adequate for a return to work. Others, perhaps much less severely disabled but less able to learn, cannot be retrained, become unemployed and thus become drawn into a hard struggle for maintenance from one or more branches of the social security or welfare system.

A particular weakness in the law in these assessments arises from regional or structural fluctuations in the business cycle, which - as studies currently in progress on the problem of early disablement show - have a considerable influence on the award of pensions which nevertheless are usually awarded in the end. The disability concept has thus developed mainly from the granting of maintenance assistance, which had to be provided by society on the basis of legal requirements and medical evidence. It was thus a case of monetary compensation in respect of a "disability" assessment made to a large extent abstractly and related to the labour market as a whole.

The group situation and designation resulting from the social legislation are without doubt as unfortunate as they are objectively wrong. Howard Rusk was right many years ago to point out that we all offer ourselves as specialists on the labour market on the strength of our qualifications and training, and that there is not one of us capable of being employed at any time in any job. Similarly, the disabled person is also to be regarded as a specialist, whose contribution as a worker is determined by the possibilities arising from his qualifications and the limitations arising from his handicap. Rehabilitation services as aids to be applied in a custom-tailored placement system of this kind must, for this reason, be offered to all disabled persons, irrespective of the cause of their disability. Although these services must take account of the medical deficiency, they are, in their scope and orientation, determined far less by the deficiency itself than by its effects on the subject's self-sufficiency and mobility in everyday life and by its repercussions on his past and future career.

The medical deficiency syndromes discussed here may be subdivided into four major groups:

1. deficiencies in the support and locomotor system
2. deficiencies in the sense organs
3. deficiencies of the inner organs
4. deficiencies in the range of mental and emotional performance.

By far the most thoroughgoing research has been applied to the rehabilitation aids required for support and locomotor deficiencies which can now be considerably reduced by such modern therapeutical measures as arthroplasty. However, account must be taken of deficiencies such as amputations, paralyses, brain and spinal injuries, the consequences of infantile paralysis and malformations resulting in permanent damage, which restrict the ability to walk and/or manual dexterity.

The capacities which remain, however, cannot be deduced simply from the deficiency itself without additional information.

At first sight defects of the sense organs also seem to be uniform in their effects, but closer analysis shows that in the case of both deafness and blindness, intelligence, adaptability and resilience play such an important part that they alone determine the employment prospects. Blind barristers have entirely different professional and social possibilities to those of a blind unskilled worker.

Much more difficult is the concrete assessment of a defect of the inner organs. Chronic damage to liver, kidneys or heart call for dietary restrictions, but also, on the grounds of vegetative malfunction, reduce tolerance to climatic stress, loss of sleep and excessive work demands. Ergonomic studies now being intensively carried out among older workers show clearly the direction in which we should be progressing to achieve a better balance between performance capacity and performance demand.

The greatest difficulties of all arise finally in the assessment of mental and emotional defects, which often restrict occupational and social rehabilitation in ways of which an anticipatory assessment can only be made with difficulty.

The easiest defects to assess are without doubt simple learning impediments. Behaviour disturbances and finally psychotic defect syndromes, on the other hand, are much more difficult.

In respect of all the defects mentioned up to now, more success has been achieved than ever before in the immediate assessment of the extent of the performance capacity retained by the subject, without imposing special exercise and a final test. Exercise periods in respect of more severe defects take at least 2-3 months and the forms of exercise used on the physical plane involve the development of muscular power, endurance and dexterity, or as Storm succinctly termed it, physical rehabilitation.

A further factor in rehabilitation is the judicious use of aids for daily living, of orthopedic aids, in particular prosthetics and orthotics, and working aids based on the results or ergonomic research, which will only reveal the extent of their usefulness after suitable exercise.

But mental and emotional functions also require careful exercise treatment by means of modern learning programmes for the recovery of school- and vocational knowledge and for training new skills and accomplishments, as a basis for qualified retraining measures.

Finally, in connection with the above mentioned learning processes, psychotherapeutic aids for the processing of the defect and for the recovery of a new partnership role in working and family life are also required. It is only when a comprehensive learning programme of this kind has been completed that it is possible to make a final assessment of performance, which, while it must take account of the limitations arising with the defect, looked at as a whole must comprise all the possibilities which the exercise programme has revealed. It is only a positive performance profile of this kind which makes it possible to give the disabled person meaningful advice on occupational and social matters; such a profile must also become a relevant part of the data already available in the form of the many job profiles and their performance demands in trade and industry in our various countries.

The disabled person who has been carefully prepared for reintegration into society in the manner very briefly sketched here is without doubt no longer an invalid to be pushed out onto the fringe of society; he has acquired in the essential prerequisites which will make it possible for him to participate fully in the life of society. It is our duty in planning social policy not just to evolve new concepts, but to accomplish the urgent social and humanitarian tasks of our time using all the institutional and organisational means at our disposal.

DISCUSSION

E. de VERICOURT

The different legislations create many injustices for disabled persons.

The difference in the conditions of compensation depending on wether the case concerns an industrial accident or a disease is often shocking.

Thus, in aviation, any cardiac disease is presumed to be accidental, whereas this is not so in mines. Infarction of the myocardium, regarded in some cases as the result of coronary atheroma, which is a disease, is looked upon by others as the result of psychic stress, which can concern us all.

It is necessary to establish regulations for compensation taking account of possible re-education, the damage caused and wether the financial means of the person concerned enable him to live decently or not.

The question which thus arises is one of justice for everyone.

S.J.H. BREUKEL

Interesting though the introductions by Mr. NOESEN and Mr. JOCHHEIM are, the essential point is the meaning of the terms "disablement" and "handicap". In my opinion it is difficult to speak of disablement in relation to the concept of work, as has also been explained in the statement by the introductory speakers.

What needs to be determined is to what extent reduced ability is a decisive argument for calling someone handicapped (in relation to the job to be done by him).

In my opinion it is of essential importance, if we are ever to harmonise our legislation, to give an unambiguous definition of the term "handicapped in relation to the job". On the basis of this the various disciplines could determine their methodologies, their cooperation and their relationships to eachother. In this connection, of course, the attitude and capacity of each candidate for rehabilitation plays a decisive role. Is it possible, in the opinion of the introductory speakers, to arrive at such a definition from the study of a diversity of individuals, that is of the actual disabled persons?

K.A. JOCHHEIM

One can only speak of a handicap if a biological defect affects the person's independence and/or previous vocational activity to a functionally relevant extent.

For instance, the loss of the little finger is not as a rule a relevant handicap. For a pianist, however, the effect on his profession is considerable and rehabilitation measures are necessary. A handicap is thus not a deviation from an abstract norm but the effect of such a deviation from the norm in the social environment.

THE PRESENT ROLE OF MEDICINE IN REHABILITATION

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Authors: G. GERUNDINI, P. HOUSSA

REPORTS

Prof. GERUNDINI

1. The Importance of rehabilitative medicine: prompt intervention and continuity of treatment

1.1. It is now universally recognised that preventive and curative medicine have been joined, particularly in the last 50 years, by a new branch of medicine, rehabilitative medicine.

Why have we chosen rehabilitative medicine as a basic subject to open our proceedings on the rehabilitation and resettlement of the disabled? Secondly, why do we insist on the term "medicine", although we know that the process of recovery must continue until the disabled person actually returns to a job, which would appear to go beyond the bounds of the purview of medicine?

We might answer briefly as follows: in assisting the recovery of patients, we treat them from the stage of the illness, in which, whilst the patient is recovering and consolidating the restoration of his faculties, at the same time he has to come to terms with sequelae which will turn out to be more or less reversible.

1.2. Particularly in recent years, now that the function of rehabilitative medicine has been clearly defined as that of human reconstruction, it has been established that if we intervene promptly, applying a strictly specialist approach, even if the disability cannot finally be eliminated, its eventual consequences can in any case be more or less successfully mitigated.

In other words we have found and are finding that if we are already conscious, at the hospitalisation stage, of the aim and process of rehabilitation and the patient benefits from close collaboration of the entire specialist team (in this initial stage, this team includes the "curing" doctors), we can secure the overcoming of severe handicaps and a surprising restoration of the morale of the patient in a much higher proportion of cases than would earlier have been expected.

1.3. The main function of rehabilitative medicine is therefore to intervene promptly, but with a long-term view, i.e. covering the entire period up to the actual economic and social re-integration of the patient; this is in contrast to the philosophy of traditional medicine, which, as it were, covers the short term and abandons the patient when a cure or clinical stabilisation has been brought about.

Rehabilitative medicine goes further, right to the end, accompanying the disabled person through all the stages of his recovery, and, for example, in the case of workers returning to a firm, will even enlist the plant doctor to continue its work.

The practical difficulties of rehabilitative medicine, thus conceived, are due to the fact that it is not a purely biological medicine, but covers the entire personality, both moral and social, of the patient: his reactions, possibilities and aspirations; it is a task which cannot be performed in the abstract, but which must be based on a sound foundation of practical caution and responsibility.

1.4. To define the basis on which the entire process of rehabilitation rests, we must begin by realising its enormous scope: it extends from the earliest stages of the illness right down to the eventual resumption of work by the rehabilitated and retrained invalid.

It is therefore a process whose origins lie right at the beginning of the pathological event: for this reason all the subsequent programme of rehabilitation must rest on a foundation of continuing vigilance and medical responsibility, firstly because the patient still requires help in returning to an active life, and secondly because his disablement does not affect all his faculties, and it is necessary to make the best possible use of the residual faculties of the affected organs.

If the patient is to be properly cured and re-integrated after his illness or injury, it is necessary to create the right climate when he realises what he has lost and begins to suffer from feelings of uncertainty, fear of the morrow and the worry that he will be compelled to live at a level below his own needs, customs and self-respect.

1.5. This awareness of disablement appears and becomes more and more pressing at the hospitalisation stage and immediately afterwards, so that a person who already feels himself to be a potential invalid becomes a prey to anxiety, lack of confidence and discouragement; consequently, while the patient is still in hospital, from the very beginning of his treatment and rehabilitation, he must be informed of his true physical condition and possibilities of recovery and reintegration into society.

This is the thoroughly human basis for modern rehabilitative medicine, whose task today is obviously wider and more extensive than that of traditional physical medicine or therapy.

Today, whilst rehabilitative medicine continues to make use of the biological and therapeutic effects induced in the patient by the application of different techniques of physiotherapy and kinesitherapy, its fundamental aim is to bring about not only a medical cure but also a recovery from the working, economic and social point of view.

In this way rehabilitative medicine fulfils society's moral duty to go further than merely looking after the existence of the individual, aiming in addition, with all the means now at its disposal, to bring about his re-integration in the family and in the economy.

We are therefore faced with a complex range of problems and the necessity for prolonged and gradual action, particularly as so many variables must be allowed for, in view of the many different kinds of illnesses and disablements, varying ages, social classes and all the other factors which go to make up the personality of the patient as a whole, involving such elements as his temperament, character, and the level of his aspirations.

1.7. In what environment and with what means is this complex process of recovery to be accomplished? We have already said that the process must begin at a very early stage, whilst the patient is still hospitalised. On the basis of physical treatment aimed at physical recovery and in particular motor-functional recovery, as complete as possible, it is necessary to instil an awareness of what actually appears to be recoverable and of what is likely to be irreversible.

It is precisely at this early stage that the rehabilitation team, taking a long-term "bed to job" view, must take the right initial steps to prepare for the eventual resumption of work by the patient.

Clearly, there are limits to what can be done in a hospital environment; patients should therefore be transferred, if their disability and age allows, to specialised functional and occupational recovery units, as soon as this is feasible.

We should like to see more such units evenly distributed throughout the countries of the Community; they must be efficient and fully able to cope with the pressing demand and changing approaches and methods. These units, providing residential, semi-residential or day treatment, must adopt approaches more suited to the requirements of the different nosological groups. Hence the characteristics of these units may vary considerably as to the composition of the team and their facilities.

In this contribution, I should like to stress the advantages of standardising the means of information and organisational foundations, in order to create a unified approach and system of collaboration, which would surely give rise to greater efficiency of action and achievement throughout the Community.

2. Need for teamwork and importance of the psychologist

2.1. All those concerned with the recovery and rehabilitation of patients in hospital and in specialised rehabilitation units must work together as a team. Furthermore, the composition of this team must be fluid, to take account of the varying requirements for different cases and different stages in individual cases; this means varying participation of members of the team, and varying distribution and weighting of their responsibilities and action.

For instance, initially the doctor providing physical treatment will be in the foreground, and his role will gradually diminish, to the point of mere specialist medical supervision. In the next stage, the emphasis will be on psychological aptitude testing and occupational advice, and here the psychologist and the occupational adviser will predominate. This phase will be followed by retraining for work and beginning to acquire occupational skills; here the ergotherapist and job instructors will come to the fore. Finally, there is the process of occupational qualification or requalification, by means of varying technical and practical courses, when the earlier collaboration will be attenuated until it almost ceases, and the actual work role will gradually take precedence.

Plainly, the doctor, the psychologist and the social worker constitute three fixed points in the team, even if the timing and extent of their functions vary; the other members of the team mentioned act and predominate at certain stages only.

2.2. Particular emphasis should be laid on the importance of the psychologist in the specialist team; his role is constantly to back up the work of the doctor. I say this on the basis of my personal experience, having learnt how important this factor is in the unit which I run, where the psychology section has always worked closely together with us.

The psychological and moral repercussions of illnesses and injuries giving rise to severe and moderate disablement constitute an important subject for research and action and are coming more and more to be regarded as a nosological and therapeutic field in their own right. The convalescent patient, in the early stages of his motor, functional and executive recovery, is not only still suffering from the shock of his trauma, but must day by day regain control of himself and recover his physical independence, at first: then, gradually, he must mobilise all his remaining recoverable latent resources, to enable him once again to become a capable, useful and self-assured person.

This critical transitional stage, in which the patient tries to regain control of himself and his faculties, may give rise to a whole sequela of minor and major frustrations, unbalances and disharmonies of character and general nervous, mental and moral difficulties. The whole person has been struck down, reduced in stature and disabled; but what primarily torments and worries him are the most conspicuous and disfiguring physical and functional disabilities, more or less directly connected with presumed deficiences or occupational incapacities.

It is at this point that the intervention of the psychologist is vital; he must stake out and define the damage sustained, lay bare motivations and difficulties, obstacles and possibilities, resolve mental tension and allay apprehension about the immediate future.

This applies mainly to the beginning of the recovery process; the work of the psychologist will, however, continue as "maintenance therapy" throughout the process of rehabilitation, and will eventually be needed in order to overcome the inevitable crisis provoked by severance from the convalescent environment and the initial return to the pace of working life.

2.3. The essential features of this approach are, firstly, that it must begin promptly, and secondly, that there must be no break in its continuity; in other words, treatments must not be interrupted, one stage must not be divorced from the next, the patient must not be left to himself for relatively long periods, and the whole process of assistance must not be interrupted until the essential phases of recovery have been completed on a continuous basis.

Any long interruption is harmful, not only because of the motor stagnation and consequent inevitable functional vacuum but also because the motions and gestures proper to every trade are bound to lose their precision, dexterity and instinctiveness.

3. Ergotherapy as the best treatment in the rehabilitation of the disabled

3.1. On the basis of long personal experience, I attach a great deal of importance to ergotherapy as one of the stages preparatory to the resettlement of the disabled person in a job.

By ergotherapy, I mean a work- or recreation-type activity defined in detail and involving technical and medical action by the patient under control with a view to encouraging and speeding up the process of his psychosomatic and social re-integration, irrespective of the nature and origin of his disablement.

Ergotherapy is thus the general name for everything done to and by the disabled person with a view to his eventual rehabilitation. However, we must distinguish different aspects and stages in the recovery process, when, in different forms and to different degrees, work is used simultaneously as supplementary therapy and as a preparation for the resumption of vocational activity.

We therefore subdivide ergotherapy into occupational therapy, general pre-working kinesitherapy and occupational ergopropaedeutics.

3.2. Occupational therapy is the first stage in the application of ergotherapy, and is the starting point for the process of occupational rehabilitation. The aim is the performance of modest work for the purpose of distraction and functional recovery of the activities of daily life, without yet concentrating on the functional recovery of the injured parts or with a view to any particular eventual occupation.

In this way, the patient, at the very earliest stages of convalescence, will be distracted by this activity from the brooding and depression which often constitute a breeding ground for neuroses.

3.3. In pre-working kinesitherapy, still general, the movement imparted to particular machines and tools shifts the activity from the field of mere occupation and distraction to the beginnings of productive activity, although at this stage the product turned out is not of any great importance and no decision regarding an occupation has been taken. However, the affected parts begin to be used and their possibilities analysed and evaluated, whilst the activity remains generalised. In particular, the more functionally sound parts of the body are stressed, and the first attempts are made to use those which are less functionally sound; at the same time, however, the entire organism is called upon for the first time to undertake co-ordinated action involving the muscles, nerves, joints, respiration, circulation, perception and attention.

In this early stage of treatment, the sessions will be short, and the effort demanded slight; periods of work will alternate with periods of rest. Gradually, without any sudden changes, there will be a transfer to machines involving less and less general and more and more specific movements; in this way, with the aid of these machines, the motor patterns demanded by the individual case will be reconstructed, particular attention being devoted to the application of muscular effort and the utilisation of the affected part.

3.4. The next stage in the ergotherapeutic process after pre-working kinesitherapy, following a logical progression both in effort and in selective mobilisation, is the last; it is the most subtle and the most taxing; we have called it "occupational ergopropaedeutics".

Let me first of all explain why we coined this specific term, which means the process of preparation for a particular work activity, which to some extent we have to insert deliberately in the general process of functional recovery. In other words, there comes a time when, after functional and general restoration has been achieved, the restored functions must be channelled into the specific acts of a specific job.

On the basis of the strictly "motor" aspects of work profiles (postures, type of motions, intensity of effort, amplitude of articular excursion, rate and frequency of work), we are able to reconstruct the motor configuration and hence the motional requirements of the working operations of the occupation in which we decide to place our subjects on rehabilitation.

Seen in this light, ergotherapy, by its admirable combination of the effects of psychological and somatic activity is an efficient instrument of recovery, bringing into play and strengthening motor resources and hence working potential, directing them towards new dynamic and structural possibilities and ultimately working towards the return of the invalid to the working climate and environment.

Ergotherapy thus defined can, together with physiotherapy and kinesitherapy, form a cornerstone of the active programme of the invalid's motor recovery and his occupational rehabilitation.

In this way, our subjects will have recovered functionnally and will have applied themselves to working with tools and machines and to the exertion of effort; they will have the advantage of having, through movement in the framework of strictly occupational propaedeutics, passed a test which will facilitate their taking a new job.

4. Conclusions

4.1. Finally, I should like to summarise what I believe to be the principal points I have raised in this contibution:

a) curative medicine must in the widest possible sense be integrated with rehabilitative medicine.

b) An overall view must be taken of rehabilitation, starting right from the initial stage of hospitalisation, i.e. when the disablement is still at the potential stage.

c) Throughout the process of recovery, it is necessary to be able to call upon the combined efforts of teams of specialists trained to deal with the different categories of disablement.

d) For me, the fundamental approach to rehabilitation must be based on the maximum use of ergotherapy (understood as preparation for work by work).

4.2. Of course, all the foregoing, which is in the nature of an introduction to the special subjects which are to follow, is to some extent surrounded by idealism; many obstacles still stand in the way of the implementation of the necessary and sufficient measures to promote the thoroughgoing vitality of rehabilitative medicine.

What is the main factor that is lacking? First of all, an awareness among the public at large of what can be done in the field of recovery and of the importance for the disabled person himself of being able to regain his status as an active citizen, even if subject to limitations. Again, we also lack comprehensive legislation covering all the means and facilities required for this public education. Above all, however, what is needed is a clear and effective vision of rehabilitation in the rehabilitation workers themselves; at the education stage, there is no academic preparation for the speciality, and at progressively lower levels, there is no preparation for the entire supporting paramedical staff.

These questions will be dealt with by Prof. HOUSSA, who will outline the possible foundations of a planned Community approach.

Prof. HOUSSA

Nowadays, medicine can no longer content itself with the correction of a deficient physical or mental state, but must, in every sphere which it encompasses, take a wider view of the concept of recovery, extending also to the future fate of the patient.

Some thirty years ago, a few doctors, attracted by this more human approach to medicine, became interested in rehabilitation, which soon became a field in its own right.

All over the world today, well equiped rehabilitation centres are being set up, having the necessary facilities for the perfect application of their techniques, but nevertheless hindered in their endeavours by lack of competent staff and in particular by doctors specialising in rehabilitation.

Why have doctors, and in particular young doctors, not followed the movement? In my opinion, it is because they were inadequately informed. For them, rehabilitation is merely a minor branch of medicine, and those who devote themselves to it are regarded as strange fellows who are in some way ridiculous. They see rehabilitation as a terminal phase divorced from the illness, which comes into play only after the patient has been cured or the case clinically stabilised. This attitude is absolutely wrong. Rehabilitation is closely bound up with any treatment of a disabling affection, and must constitue an integral part of medicine on equal terms with preventive medicine. Paradoxically, in spite of this, there is in many countries no systematic education in rehabilitative medicine.

This gap has not escaped the attention of the international organisations, which have many times drawn the attention of governments to it. It is advocated by the World Health Organisation, and the Committee of Ministers of the Council of Europe, in its resolution AP 69 4, adopted on 27 June 1969, demonstrated its interest in the training of rehabilitation workers.

These organisations recommend the introduction of training in rehabilitation in the regular curriculum of medical students, who are completely ignorant of the whole matter. It goes particularly unmentioned in their lectures, and very few students indeed ever take a course in rehabilitation or work for a few months at a rehabilitation unit, achieving an understanding of the fundamentals and realising that rehabilitation, far from being a minor branch of medicine, by strengthening the bonds between patients and doctors, is a credit to the profession.

In most western European countries, the rehabilitation applied in the last thirty years was introduced by doctors who concentrated particularly on accident victims, and therefore treated locomotor disorders. However, rehabilitation gradually emerged as a complement to a larger number of treatments. The success of rehabilitation depends essentially on the participation of the medical profession, because the doctor will always be the man in charge, prescribing and supervising the process of rehabilitation or guiding his patient. If doctors are to be in a position to fulfil these tasks, they must first and foremost be informed. However, it would appear that in many countries this information is lacking.

Rehabilitative medicine has progressed too far in all fields and disciplines for it to be sufficient merely to have read a few articles gleaned at random from publications in order to practise it. What is necessary is a solid foundation of knowledge of the different techniques, to enable the doctor to prescribe treatments, and even rudimentary notions of the field of employment and occupations, so that the doctor has some idea of the type of job a person with a particular disability is able to do, etc. It is an important subject, and it has to be recognised that at present departments of rehabilitation are extremely rare in Europe and programmes are not always comprehensive. Yet it cannot be denied that rehabilitation remains basically within the purview of medicine, although it cannot be implemented without the help of paramedical staff.

The doctor has to make a diagnosis, weigh up the situation precisely, prescribe a procedure and supervise and monitor it so as to be able to adapt the techniques to the evolution of the case. Furthermore, he must remain in touch with the follow-up, so that he can compare the hoped-for results with the actual results.

It follows from the foregoing that the job of the "rehabilitator" is important; at present there are two almost opposite schools of thought, one of which sees rehabilitative medicine as a specialisation in itself, covering all disabling affections, wether sensory, mental, or otherwise, whilst the other splits it up into specialities.

It is not our purpose here to criticise these divergent theories, but to emphasise that it is essential at the present time for all doctors to have a sufficient notion of rehabilitation to know what can be expected and either effectively to channel their patients to specialised units without making promises to them which cannot be kept, or to take account during the acute phase of the affection of the possibilities of rehabilitation and not to jeopardise the re-integration of the patient by serious errors (for example deformity of the feet of a long-term bed-patient is often an impediment to the resumption of walking); furthermore, the doctor must not assume that disabling sequelae are an obstacle to the resumption of an activity.

As we have pointed out, medicine is taught on the foundation of the pathological affection, whilst in rehabilitation events take place essentially on the level of the pathogenic agent, i.e. the patient. In consequence of his illness or accident, the patient is confronted with personal, family, social and occupational problems, and it is, of course, necessary to take this context into account if he is to be helped fully. It is therefore essential to be able to lend an attentive ear to his troubles, and to spare the time at his bedside to explain what is being done for him, what he can expect from the treatment, and also what he cannot expect, since promises that cannot be kept and hopes which are disappointed do more harm than good. Time must be found throughout the duration of the treatment to continue this unique dialogue, with its immense value to both doctor and patient.

Another point to be borne in mind is that rehabilitation can never be a one-man effort. It requires teamwork and the influence of the paramedical members of the team is enormous. The doctor must learn to listen to them with the same patience and attention. Their comments are as a rule valuable, sometimes shedding light on obscure points, because they too have to learn about rehabilitation, not only about the theory and recommended methods but also about the spirit, and more especially, the team spirit, in order to present a united front and display the confidence and understanding needed to help the patient to follow the long road to rehabilitation without discouragement.

All these concepts and many others must be included in the rehabilitation training course, since everything is different in a rehabilitation unit. In such a unit, the patient cannot be treated in the same way as in a conven -

tional curative medical unit, where he stays for a short time only, and where the treatments are more easy to apply.

With rehabilitation, stays are longer, progress is very slow, and the co-operation of the patient must be enlisted.

In addition, there are the fields of vocational guidance, occupational re-education and social re-integration, which are remote from medicine, but of which at least the rudiments are essential for the success of a rehabilitation programme and for the achievement, at least in certain cases, of the optimum result, which is the resumption of gainful work under good conditions and the restoration of the patient to his place in the economy.

Indeed, rehabilitation appears to consist of different sectors, sometimes remote from each other, each of which, like the links of a chain, are essential if gaps are to be avoided. It is necessary to ask what everyone involved can contribute to the benefit of the patient.

For example, kinesitherapy will bring about the re-education of the muscles, assisted be ergotherapy, more constructive in that it also encompasses psychological action; nurses can also exercise a moral influence which may be of extreme importance (in the United States, they have extensive responsibilities in this connection).

Social welfare workers, teachers, instructors, monitors and leisure-educators all have a part to play, but the doctor must remain the co-ordinator.

In any case, the teaching of rehabilitation can only be beneficial firstly to the patients, but above all to the paramedical group, who will achieve a better understanding of their role and their irreplaceable position in the team, as well as to all qualified doctors, who will have a full knowledge of the facilities available and be able to channel their patients to the right specialised units. It will be particularly valuable for young doctors, who at a time when the profession is endeavouring to depersonalise itself and get away from the clinic will rediscover their obligations under the Hippocratic oath, of being the confidant, counsellor and indeed the friend of the patient, thus re-establishing the human relationship and providing a source of consolation and hope without which the patient cannot live.

DISCUSSION

It has been decided that the discussion on "Present role of the medicine in rehabilitation" and "Occupational rehabilitation" should take place in one session - (see page 113)

OCCUPATIONAL REHABILITATION

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REPORTS

Prof. PIERQUIN

1. Historical notes and terminology

1.1. Introduction

1.1.1. The return of disabled persons to suitable employment has always been considered as the main objective of rehabilitation, for the simple reason that the performance of a job is the surest sign of independence and guarantees the possibility of making all kinds of acquisitions and meeting normal needs.

Society in turn derives various benefits from the work of disabled persons. As full time "economic agents", they produce, consume and pay taxes like everyone else. Their role is vital in a policy of full employment.

1.1.2. As long ago as 1940, the International Labour Conference laid down in a number of recommendations to governments, the policy to be followed to enable disabled persons to return to work, thus respecting the right of every human being to employment. In this way the principles and rules of occupational guidance, occupational training and employment were laid down (1).

As a result of this enlightened advice, the decisions of national public authorities and the efforts of various specialists, the essential aspects of the process of preparing disabled persons for their return to work now seem to have been dtermined. Victims of illness or injury first benefit - in hospital and then if necessary in special centres - from special care given by doctors and their assistants; this treatment is known as "medical or functional rehabilitation". If they are completely cured or only slightly handicapped, they return to their previous job at the end of this period. If this is not possible, their remaining aptitude is evaluated by "occupational guidance" specialists; some patients then return to a suitable activity in their old firm while others learn a new job, i.e. undergo new "occupational" training before taking up employment.

1.1.3. In practice there are many complications; some disabled persons cannot return to work immediately after medical rehabilitation and cannot undergo real occupational training because their educational and intellectual level is too low. These patients form a large group; they are able to return to work after measures which may be summarized under the heading of "occupational rehabilitation" following medical rehabilitation. We believe that the same measures can also be used in conjunction with occupational training in the true sense of the word.

1.2. Historical notes.

1.2.1. The British seem to have solved this problem through a wider and more comprehensive notion of "medical rehabilitation". The latter is not confined to correction by physiotherapy and occupational therapy of the impaired basic functions (paralysis, ankylosis). Through an extension of the practical measures used, it tries to remedy the shortcomings in the complex, overall functions of the organism which are often inhibited by the injury, illness or lack of movement. Through ancillary measures and wider treatment it usually manages to lead the disabled person back to a condition in which he is able to take up work again.

However, disabled persons who - because of their disability - cannot obtain or keep a job are received in special establishments known as Industrial Rehabilitation

Units (I.R.U.) which differ from the Vocational Training Centres (2). Here they are encouraged and enabled to work; they perform gymnastics and are gradually guided towards a particular employment. On leaving these establishments they work either in ordinary firms or in protected workshops (Remploy).

1.2.2. Some specialists in France were confronted with this problem during the second world war in connexion with the rehabilitation of victims of pulmonary tuberculosis treated in sanatoria. They introduced the term "effort retraining" to designate the general physical and mental activities which these patients needed to develop to overcome their inertia and return to work or receive vocational training. The same term was later used in France for other patients (mental and cardiac cases) who were obliged - like the tubercular cases - to live in isolation for long periods and rest completely (3).

In the sphere of rehabilitation of victims of industrial and road accidents, the problem did not arise in the same manner and, with a few rare exceptions, the term "effort retraining" was not used.

Most specialists responsible for the functional rehabilitation of accident victims adopted until recently an attitude which was too medical, i.e. concentrated excessively on analytical or segmentary kinesitherapy. Now, however, they are tending to broaden their outlook and practical approach by developing ergotherapy and organizing general physical exercises in the gymnasium.

So far, however, there are no systematic arrangements in France for effective rehabilitation to cope with the procedures and conditions of work, although in our opinion, a system with precise objectives and a rational organisation is indispensable. Our report describes an experiment on these lines (G. CAHEN).

1.2.3. In Belgium the situation is broadly similar. We describe one exemplary initiative taken under the heading of effort retraining (A. STORM). This is an attempt to extend and accentuate the benefits of analytical, functional rehabilitation through the practice of general exercises preparing the patient for a return to work and social life.

1.3. Terminology.

It is important to recall certain definitions which have been generally adopted and are widely used, in order to situate the subject dealt with in this report in its general context.

1.3.1. Rehabilitation is the process of adjusting the disabled person to his environment; retraining is the application of educational methods to make this process more effective.

1.3.2. Rehabilitation or functional retraining is the correction of disorders of the motor, sensitive, sensory and visceral functions having their origins in pathological causes. This result is achieved mainly by physical exercise (kinesitherapy) and work (ergotherapy), specially selected and prescribed to correct the disorders concerned.

1.3.3. Rehabilitation or vocational retraining - or more accurately occupational training - is the acquisition by the disabled person of technical knowledge of a theoretical and practical nature to enable him to take up a new occupation.

1.3.4. Occupational rehabilitation is the adjustment of the disabled person to the physical and psychological conditions of his future job, whatever it may be. This form of rehabilitation is always effected in two ways which necessarily go together: gymnastic activity and workshop activity, both selected and controlled with reference to the demands of the job.

These activities constitue a follow-up to functional rehabilitation and are each in turn intimately linked with it; they only cease when the subject has returned to work.

They may prepare and accompany vocational training.

Depending on the predominance of one type of activity over the other, or rather depending on the specific or vocational nature of this preparation, a distinction can at present be made between:

- restoration of physical faculties (effort retraining A. STORM) and
- restoration of work capability (G. CAHEN).

Dr. STORM

2. Occupational Rehabilitation

2.1. Restoration of physical faculties

This paper is based on experience acquired at the Traumatology and Functional Rehabilitation Centre of the Reine Fabiola Hospital at Montignies-sur-Sambre, Belgium; this Centre was established in 1958 on the initiative of the Common Insurance Fund of the Coalmining Industry of the Charleroi and Basse-Sambre Basins for the benefit of victims of industrial accidents in the coal mines. It owes its existence to the action of Monsieur Jean LIGNY, President of the Board of Directors and the supervision of Dr. DESENFANS, senior consultant. The Centre continues to receive victims of accidents in the mines as well as others from many industries in the region and country as a whole. It also takes in male and female patients from other branches of medicine: neuro-surgery, rheumatology, orthopaedics, pneumology, cardiology.. Their age varies between 10 and 80.

The functional rehabilitation centre forms part of a hospital complex in which the ultimate aim is the complete restoration of the patient's previous static and dynamic condition.

2.1.1. Purpose: the restoration of physical faculties is part of the process of functional rehabilitation. Its objective is to restore the patient to the condition he enjoyed before the accident by enabling him to recover all his previous faculties of work and employment - independence in his home and in the street, use of public transport, restoration of all the major functions.

Definition: the treatment consists in methodical and global activation of the physical and mental functions. It concerns the organism as a whole and not merely a part of the body. Its content varies fairly widely as a function of the needs.

2.1.2. Means used: rehabilitation team and equipment.

The return to previous activities must be prepared from every angle: physical, psychological, administrative, occupational and social. The value of preparation through effective liaison is therefore apparent.

In addition to the senior specialist doctor or surgeon the team will include a physiotherapy specialist, a physical education instructor, kinesitherapeutic expert, ergotherapist, social assistant, psychologist, medical-administrative secretary and possibly also a work advisor, prothesis expert, industrial doctor, workshop supervisor and dietician (4).

- Equipment (5): physical training hall comprising: horizontal and vertical ladders, balancing beam, Swedish gymnastic benches, rib-stalls, frame guide or bars for muscular exercises, climbing frames and various weights for handling exercises.
- area for group physical activities (job-related gymnastic activities and games).
- analytical retraining hall with pulley-therapy, massage and physiotherapy cabins.
- hydrotherapy: therapeutic swimming pool (minimum 7/3 metres).
- ergotherapy: weaving, carpentry, wrought iron, pottery workshops etc..
- garden with special layout to exercise disabled persons

2.1.3. Techniques: physical activities.

2.1.3.1. Basic characteristics.

- Physiological analysis of exercise.

Through educational and physiological analysis of movements, the exercises will be adapted to the type of disability under treatment. For example the repetition of a movement is not simply a matter of muscular training; it also involves cardio-pulmonary adaptation. A simple formula recommended by Bellin du Coteau (6) enables the characteristics of physical exercise to be analyzed:

- speed = mainly cardiac factor
- skill = mainly neuro-coordination factor
- resistance = mainly cardio-pulmonary factor
- endurance = mainly cardio-pulmonary factor
- strength = mainly articular and muscular factor.

Resistance and endurance are very closely related with one slight difference: resistance is the quality which enables an effort close to the maximum to be continued for a certain length of time while endurance is the ability to sustain an effort of relatively low intensity for a long time

Speed is a question of contraction in a minimum length of time, skill depends on the difficulty of the movement and strength is the dominant factor in slow, controlled movements (which are not often repeated) with maximum load.

This analysis already enables exercises to be chosen in the light of the dominant action.

Example: - it takes strength to climb onto a stool
- it takes strength and endurance to climb several flight of stairs
- it takes strength, resistance and skill to climb a scaffolding of x steps and cross several ladders.

- Job-related movements

Job-related movements imply physical effort and physical exercise. However, rather than trying at all costs to "label" imprecise jobs, it is better to adopt the language of movement described by Delat and Lobet (7). Their book contains exceptionally valuable documentation. Their analysis of 1300 occupations picks out 43 movements plus all their combinations which enable any job to be performed. This study has guided our work in directing the patient's effort towards more analytical reeducation as a function of his occupation. Nevertheless it is too analytical to be chosen as a basis for physical rehabilitation.

Since most jobs are characterized by repetition of certain limited movements, it is not good enough to turn the individual into a "robot" during the rehabilitation course.

- Classification of the worker's movements (8)

Three categories:

- movements required in the occupational environment: climbing a ladder, throwing a brick, etc.. We know that a carpenter or mason must do more than merely handle his tools: he must climb ladders, maintain his balance and move over scaffolding sometimes at considerable heights while handling objects; the crane driver must not only estimate visually vertical and horizontal alignments and operate controls, he also has to fight dizziness while raising loads.

- purely technical movements guided by a mechanism: turning a handle, pushing a lever or carriage. These movements are at the bottom of the hierarchy of difficulty. They occur in an infinite number of jobs in modern industry.

- purely technical movements controlled by a skilled mind: filing, forging, painting, welding. These are the movements of the skilled and qualified worker or specialist.

- Fundamental factors in human work.

Strength, speed and accuracy are the basic factors in human work. Strength varies with the technique involved. It may be continuous, intermittent, sudden or progressive.

- sudden application of strength, gripping an object in the whole hand: the forge worker;
- accuracy and strength are essential to a cook when he cuts meat, in addition to the different forms of gripping;
- multicopying work requires speed and accuracy but also muscular endurance in the movements: press operation.

As a result of mechanization, the strength factor is increasingly being replaced by a need for speed and accuracy; these two factors cannot be disregarded.

- Job categories in terms of intensity of work.

Jobs can be divided into four categories:

- heavy work requiring strength, skill, accuracy, resistance and speed (forge worker, miner at the coal face). The scaffolding erector is not only skilful with his hands, he also needs skill to keep his balance;

- semi-heavy work in which all the dominant factors of exercise are called into play but to a lesser extent (fitter, painter). The power line electrician combines skilful working movements with a sure grip for his own safety;

- occupation in which work and rest alternate (artisan, shop-keeper. A driver does nor merely drive his lorry; he uses all the time the digito-palmar grip which is essential in his profession but at some points he will have to handle goods;

- sedentary occupation in which some of these qualities are needed; however, there is no absolute requirement for the dominant cardio-pulmonary factors (dressmaker, clerk, multicopier, telephone operator,).

These different characteristics show that it is almost impossible for the rehabilitation specialist to know every job; however, by asking the patient detailed questions on his occupation it is possible to draw up a programme of activities centring on the major functions.

2.1.3.2. Basic requirements: General motor skills

Exercises with no change in level:

- walking, running, crawling, falling.
  Example: fitter carrying a gas cylinder

Exercises with change in level:

- movement on apparatus - without load
- movement on apparatus - with load
  - climbing up and down, jumping
  - clinging, gripping, hanging
  - negotiating obstacles (overcoming dizziness)
  - climbing a ladder while pulling a cable,

  this work can be extrapolated in gymnasium activities.

Manual handling

- lifting, carrying, transporting, throwing, laying down, pushing.
  Example: replacing a truck on the rails; lifting technique.

In the rehabilitation hall attention is drawn to the key points in a proper handling operation

- movements of the ceiling plasterer, tiling worker
- pushing a lorry, represented by a rugby scrum.

Accuracy of movements

- handling and coordination (throwing tools, bricks).

2.1.3.3. Programme (9)

1st programme of general gymnastics including the dominant factors of exercise. All the accessible segments of the body are treated. Since most patients cannot stand upright continuously or support themselves on one leg, the exercises are carried out with the patient sitting on a stool or lying down.

2nd programme of general gymnastics for patients who have made average progress or reached the final stages of treatment; these exercises concentrate on cardio-pulmonary factors;

Walking: to enable the patient to recover all the movements needed to walk on any type of surface and use public transport. The progression will be as follows: ordinary walking, walking with negotiation of scaffolding and running.

Games and sport, not only contribute to restoration of the patient's general condition but also enable him to recover physical qualities through recreation. The participation of disabled persons in sport eliminates certain barriers which would otherwise remain insurmountable.

Job-related gymnastics.There are two main categories:

- Specific gymnastics: group gymnastics concentrating on an injured limb or segment. General exercises with an analytical aim. The intensity and rythm of the lesson has cardio-pulmonary implications.

- Applied gymnastics: this is necessary for the patient suffering from any type of lesion when he reaches the end of his treatment. There is no longer any medical problem, i.e. perfect consolidation of the bones, no cardiac contra-indication, adequate muscular strength, full articular amplitude. In addition to exercises in manual handling, exercises with or without change in level and exercises in accurate movement, the lesson will comprise one or more key movements. Balancing exercises are also important. The lesson must not only take into account the three groups of occupational movement and the dominant factors in exercise but also the general motor skills. It would of course be impossible to introduce movements specific to one particular trade without having hyper-specialized centres for given occupations.

Muscle-building (10, 11). This muscular training or physical conditioning is an activity over and above the work capability of the disabled person who needs strength, endurance and agility in his job (with or without technical skills).

Hydrotherapy: apart from the whole range of controlled analytical therapy exercises, swimming and games are the main activity.

Moving pavement: use of this installation at different speeds and slopes increases the ability to make an effort and objectively improves certain dominant factors in physical exercise.

Use of the ergometric bicycle on the other hand in the seated or lying position, improves other qualities and it is possible to control the articular amplitude and muscular strength required.

Ergotherapy: depending on the desired intensity of effort, basket making, weaving, pottery, wood-working, wrought ironwork and gardening activities enable the patient to become accustomed again to a prolonged upright position, to walking and manual handling while focussing his attention on the production of an object as a centre of interest.

These activities are organized individually or in groups. The psychology of the disabled person is very important; we must never forget that the individual is a whole person. A good number of failures are due to this fact being disregarded. Group work produces a competitive atmosphere and also encourages a desire to do well in the participants. This collective rivalry also leads to mutual assistance.

We must be absolutely sure that when a patient leaves the Centre he is physically and morally sound and in a fit condition to resume his work. Attention must be drawn to the key factors of safety and accident prevention. Safety is not a separate area or an occupational ethic: it is inherent in the technique used. The emphasis must be placed on reflex qualities and good reactions since one of the basic requirements for a job well done is good physical condition. The opportunity must be taken to introduce notions of safety and first aid.

A fatalistic acceptance of the risks of the trade must be countered. This can normally be done in the Occupational Schools and Technical Institutes but the Rehabilitation Centre also has its part to play.

The working man who is not safety-conscious is as incomplete a person as an educated man who is discourteous.

When additional training is necessary, the role of the rehabilitation centre is to give the disabled person the necessary technical assistance to perform the movements of everyday life and to condition himself in the use of these movements.

2.1.4 Organization and operation (4) (5)

2.1.4.1. The sum of activities proposed to the patient
2. in a six hour day confers a specific
3. character on occupational rehabilita-
4. tion. This intensity may seem excessive, but it is essential in a great many occupation.

The dialogue begins as soon as the patient enters the Centre. He is received by the social assistants and during this initial contact the atmosphere in which he will follow his course of treatment is explained to him.

The social assistant examines the patient's family and occupational situation and tries to arouse a climate of confidence which will enable the patient to participate more satisfactorily in his rehabilitation. This essential action is already a form of psycho-therapy and is more often than not sufficient to make a start on moving towards a suitable solution.

In every phase of functional rehabilitation, the patient must be active and responsible for his own cure. The members of staff and equipment provided for him are simply the means of arriving at his social reintegration. One of the duties of the rehabilitation team is to help him. The injured person must be fully informed of his own real interests through attentive psychological care, without a brusque or flattering approach; firmness must be allied with flexibility and friendship.

Each staff member in his own particular function will constantly urge the patient to participate actively. Participation must be encouraged, developed and sometimes guided. To understand the individual, each member of the team will make a personal effort to "put himself in his place"; the whole programme will be aimed at helping him to resolve the difficulties confronting him in order to overcome his anxiety and gain a feeling of security so that he can participate wholeheartedly in the process of rehabilitation and reach the ultimate aim of social reintegration. Every individual involved in the process must bear these objectives in mind.

So that everyone can obtain the necessary information, the patient is introduced to each member of the team. As the treatment progresses, staff meetings are held at regular intervals for consultation and planning purposes. During these meetings, the various activities in which the patient may participate are prescribed on the basis of his articular, muscular and functional condition. Attention will be drawn in particular to the contra-indications.

This system of consultations enables the patient to see that his programme is constantly prepared and modified on the basis of medical and rehabilitation requirements; his progress is guided through a constant dialogue.

Progress is discussed every day with all the staff and a report drawn up at the end of the day.

2.1.5. Results.

In this way it is possible to obtain a gradual transition from disability to normal work or employment at a specially adapted working position.

The return to work and social reintegration must be prepared from every angle through effective liaison between doctors, psychologists, administrative, occupational and social specialists. The opinion of all the specialists must be obtained first. This preparation is a pre-requisite for success.

At this stage there is an interplay between human and economic interests. Insurance Companies, the Social Security Organization, company managers and trade unions should understand the need for this phase and make that it can be properly completed.

Rehabilitation Centres, industry, schools and the staff working in them are nor properly informed on this problem.

Medical faculties, higher institutes of kinesitherapy, ergotherapy and physical education should give their students fuller information so that the necessary conditions can be met more widely in practice.

Dr. CAHEN

2.2. Occupational rehabilitation (restoration of work capability

The practical example described below complements the above description and is in no way contradictory to it. The difference resides in the importance given in this instance to the study and preparation of the occupational component of rehabilitation (12).

2.2.1. Aims and definition.

The occupational rehabilitation centre receives all workers who, as a result of accident or illness and after the medical, surgical and functional retraining treatment are unable to return to their former job or would encounter major difficulties in coping with it unless they receive special preparation. In addition the centre deals with disabled adolescents who raise guidance problems at the start of their professional career.

The purpose of the subject's stay in the centre is to continue and complete his physical or mental training, to select the best occupational solution in the light of all the data and prepare the subject to take up this occupation. If occupational training is necessary the subject is then sent to a suitable establishment.

The organizers of the centre wanted the occupational rehabilitation programme to be quite distinct from medical or functional rehabilitation through the environment, staff, installations and techniques of the centre. The environment of treatment is gradually replaced by a working environment. It was possible to achieve this aim all the more easily as the centre forms part of a large group of services or establishments which ensure early rehabilitation at the hospital stage and post-hospital functional rehabilitation for children and adults; the succession of phases of rehabilitation and the transfer from one department to another are completed without difficulty or interruption. The occupational rehabilitation centre has been able to devote all its efforts to the development of arrangements and activities directed specifically towards its objective.

2.2.2. Means and environment.

2.2.2.1. Rehabilitation team.

Since the disabled persons undergoing treatment are frequently suffering from serious after-effects which are still changing (i.e. not consolidated in the sense defined in French legislation on industrial accidents), the technical administration of the centre is medical but the three doctors who are qualified in functional rehabilitation and retraining, benefit from the continuous and essential assistance of two occupational advisors. As soon as the subject enters the centre, these advisors maintain or reestablish contact with the former employer, and determine the requirements of the job as well as the possibilities for adaptation or transfer within the firm. They act as permanent advisors to the team on all occupational problems and clearly play a vital part in occupational guidance.

The remainder of the technical staff consists of a social worker, five kinesitherapeutic specialists, five gymnastic leaders, one ergotherapeutic expert, six workshop supervisors, nurses and a schoolmaster.

A psychologist, a psychiatrist, surgeons and an occupational psychologist from the regional psychotechnical selection centre also act as permanent consultants.

2.2.2.2. The premises.

The medical and technical premises consist essentially of kinesitherapy rooms, a large gymnasium and outdoor gymnastics area as well as a group of six occupational workshops.

There are one hundred beds for resident patients and the centre also receives some thirty day boarders who live in the nearby town.

The patients are for the most part male.

2.2.2.3. Pathology.

The range of disabling conditions is very wide but traumatic injuries represent more than 80% of the total, 60% of these being industrial or road accidents.

2.2.2.4. Recruitment.

The geographical recruitment area is the Lorraine region. 95% of the patients come from the Meurthe-et-Moselle department and from the three neighbouring departments.

2.2.2.5. The atmosphere.

The atmosphere is very different to that of a hospital: the subjects are for example able to come and go freely outside the activity periods. They wear sports clothing or working dress as the case may be.

Victims of illness and injury are admitted on their own request or at the request of doctors. There is one reception day each week. The stay ends when we consider we have completed our role. The arithmetic mean of periods in the centre is about eight weeks at present.

The activities are spread over six hours each day, divided up into four ninety minute sessions. The progression of training is not effected by increasing the number of hours of activity but by gradually changing the content of the course.

2.2.3. Techniques.

2.2.3.1. Physical exercises.

The activity of our gymnastic section is based on the principles outlined earlier (see 2.1.3.). Although our terminology and organization are very different, the physiological principles, installations for occupational gymnastics and broad outline of the techniques used are much the same. We shall not therefore discuss this aspect again. It is simply worth noting that the size of our staff and installations enables training groups of 10 to 20 subjects to be formed; these groups are relatively homogeneous having regard on the one hand to the disability and on the other to the occupational aim of the training. The professional gymnastic activities do not consist in the training and repetition of occupational movements (this is the task of the workshops) but in preparing the body and mind through similar movements which are less precise and perhaps more demanding. They prepare the subject to use the installations and equipment he is likely to encounter in his work. They are also an education in safety. Physical aptitude is regularly measured on the basis of certain standard tests; these enable the subject's progress to be determined in objective terms; his weakpoints can easily be discovered and the level of attainment compared with the physical requirements of the proposed employment.

The kinesitherapeutic specialists prepare or supplement the training given in the gymnastic department. They also concern themselves individually with certain seriously disabled subjects who cannot take part in the collective treatment.

2.2.3.2. Workshop activities.

Six workshops allow a wide range of activities:

- the light activity workshop with functional ergotherapeutic activities; subjects are received and kept occupied here while awaiting a prothesis or physical improvement; the first aptitude tests are also carried out here.

- the observation workshop houses various activities ranging from welding to draughtsmanship and electrical engineering to accountancy.

- the workshops for pottery and mosaics, carpentry, mechanical engineering (all types of ironwork, fitting, machine tools, forging, welding) and outdoor work (building, earth-moving, painting, gardening) help in giving general non specific training (strength, coordination, endurance and sometimes development of the necessary compensations). They also allow specific training for the envisaged job (working position and occupational movements, technology, quality and output).

They offer a whole range of activities with increasing physical demand and complexity. In general the progression of training is obtained by successive participation in different activities in one or more workshops. It was of course impossible for all the occupational activities of the region to be represented in the centre; however, working by analogy, it is almost always possible to reconstitute the basic requirements of the desired employment. When it appears after a number of tests that a given activity may be chosen for detailed training a more precise aptitude survey is carried out. This is based on a series of essentially practical tests, standardized in advance, which supplement the psychotechnical tests

The final training takes place:
- either at the disabled person's normal place of work,
- or at different places which reconstitute the basic working operations.

The items produced in the workshops always have a use:

- objects purchased by the disabled subjects;
- supply of items to equip and maintain the centres.

The workshops are organically linked with the Reemployment-Resettlement department which facilitates their harmonization with the regional industries.

The workshops are run by supervisors (not by ergotherapeutic specialists) who have acquired certain para-medical knowledge but are primarily "professionals".

2.2.3.3. Associated techniques.

2.2.3.3.1. Psychological examinations and social enquiries often provide the explanation of difficult behaviour and sometimes the means of changing it.

2.2.3.3.2. Psychotechnical tests reveal intellectual and educational aptitudes which could benefit from occupational training (according to criteria used nationally). They may also help to guide the subject towards a direct return to work.

2.2.3.3.3. The presence of a schoolmaster enables knowledge acquired in school to be revised, and brief further training or sometimes initial schooling to be given. This tuition is sometimes sufficient to allow training which would otherwise have been impossible to be followed.

2.2.3.3.4. The equipment workshop located in the establishment, enables suitable protheses to be prepared quickly for amputated subjects.

They can then be tested under genuine occupational activities and modifications made if necessary.

2.2.3.3.5. The occupational survey.

This gives information on the occupational situation at the time when the subject stopped work and on his past career. It shows the possibility of resuming work at a later date either in the old establishment or elsewhere.

2.2.4. Organization and operation.

The aim is to study the progress of an individual case through collective activities. This is made possible by great flexibility in drawing up activity programmes. The treatment, exercises or work which seem most desirable at any given time in the course of training are prescribed in the appropriate proportions.

Our working method is guided by two major principles:

- teamwork
- continuous guidance.

2.2.4.1. Teamwork: Members of the team are all bound by professional secrecy. Information concerning a subject is forwarded to all members of the team and there is a permanent exchange of observations and opinions. Major decisions (progress, change in the programme, proposed occupation, discharge) are taken under the responsibility of the doctor who has obtained the opinion of each team member at the weekly "progress" meetings.

2.2.4.2. Continuous guidance: Apart from rare cases where the occupational target can be clearly defined from the outset, we do not define a particular job at an early stage. This cautious attitude is due to uncertainty about the functional prognosis until all the training resources have been exhausted and also to the relative nature of certain medical contra-indications.

We have often seen victims of injury whose return to their previous job seemed jeopardized by the importance of the after- effects from which they were suffering, make unexpected progress during training so that eventually they were able to cope very well with the requirements of their original vocation.

Unfortunately it is not uncommon for the opposite to occur too: an unexpected cessation of progress and unforeseen difficulties may make it necessary to abandon during the stay in the centre a solution which seemed reasonable at the outset.

Finally there are many cases in which there is no good solution and we are obliged to choose the least disadvantageous by knowingly disregarding relative contra-indications which would have coloured our decision in more favourable cases.

The activity programmes are therefore constantly revised as a function of progress made, and the envisaged solutions or tests and at the same time the solutions which are adopted clearly depend on the results of these activities.

As far as we are concerned the notion of occupational rehabilitation is inseparable from that of occupational guidance. The conclusions eventually reached must therefore take into account medical, physical, psychological, educational and technical factors as well as the subject's motivation, his family situation and previous occupational background. With the exception of some 10% of the cases of disability a solution of reemployment is always found.

2.2.4.3. Reemployment: this service is the responsibility of employment advisors. Several different solution are envisaged (13).

2.2.4.3.1. A direct return to the previous job. The employment advisor will have been able to study the characteristics of the available posts by correspondence or visits. He may recommend a return to the identical job or to a different position which is better suited to the subject's remaining aptitudes.

2.2.4.3.2. Reemployment through the official employment departments (National Employment Agency).

A suitable post must be found with a new employer. In this case we give the Agency all the information likely to facilitate its task; we stress the jobs which appear feasible to us and not jobs which the subject cannot perform - an indication which is too often given. Our proposals are sometimes forwarded through the Departmental Committee for the Guidance of Disabled Persons, the official resettlement organization.

2.2.4.3.3. We also forward to this authority our proposals for occupational training in specialized centres for physically handicapped persons or in occupational training centres for adults.

2.2.5. Results.

The average results achieved in recent years can be summarized in three percentages:

- direct return to work, in half the cases in the previous post and in the other half in a more suitable job in the same organization 75%
- temporary or permanent disability 10%
- occupational resettlement 15%
  including:
  - direct placing by the official agency 7,5%
  - occupational training 7,5%

2.2.5.1. The results obtained and the action taken on our proposals are checked. Questionnaires are systematically sent out six weeks after the subject leaves the centre and again six months later so that we are able to examine the situation twice. Questionnaires are sent both to the worker and to his employer; we therefore obtain two opinions.

A recent survey conducted by an organization which has no connexion with the centre and has substantial means at its disposal, showed that these questionnaires are adequate in most cases and enable us to obtain perfectly valid statistics.

When subjects are discharged, correspondence is of course established with the doctors and surgeons responsible for the patient and also with industrial health officers and social assistants. This enables us to follow up a number of difficult cases more directly.

We should, however, like to be able to extend our action - in certain cases at least - by visits of medical, social and occupational teams to the residence or place of work of the subject.

Fifteen years of experience have convinced us that occupational retraining in this form ensures a return to work under optimal conditions. In the great bulk of cases, the subject returns to his previous job, but the possibility of acquiring skills or additional qualifications - as a guarantee of greater security and independence in the future - is never disregarded.

Prof. PIERQUIN

3. Rehabilitation methods used at present: pros and cons

3.1. Occupational rehabilitation in a fundamental rehabilitation department or centre which is an integral department or annex of a hospital system necessarily has a primarily medical and gymnastic emphasis. It is difficult to consider occupational activities in these establishments and organize effective workshops. It is difficult to combine rigorous and precise kinesiological and physiological directives and supervision (which make for excellent results) with an equal measure of occupational competence. The best results will be achieved with this method if it forms part of a broader system leading up to reemployment.

3.2. On the other hand occupational rehabilitation in a specialized centre, geographically remote from the hospital environment, enables workshops, sites and a whole system of continuous guidance, social studies and links with companies to be established. There is even a risk of excessive emphasis on work if the centre is isolated from the health services responsible for functional rehabilitation and if its staff only includes occupational specialists to the exclusion of doctors, reeducators of the motor system and gymnastic specialists; the desire for production must be held in check by the need to satisfy the human requirements of disabled persons.

In general, occupational rehabilitation centres are set up as multi-purpose units; they accept disabled victims of illness or accident of all origins and kinds, provided that the patients are suitably grouped. These centres have the advantage of well-equipped installations so that every disabled person can choose the activity best suited to his own case from a wide range of possible activities.

3.3. Specialized rehabilitation centres are always smaller and lack the above advantage but they make up for this shortcoming through greater attention in special sectors.

3.3.1. Some of them concentrate on the rehabilitation of specific pathological groups.

The specialists whose responsibility it is to enable victims of accidents to return to work must study post-traumatic pathological aspects of the case as well as the physiological and psychological problems of the worker suffering from a specific disability and difficult problems of movement compensation, adaptation to the place of work and safety. Their techniques of occupational rehabilitation can be rationalized to a very considerable extent.

Occupational rehabilitation of tubercular patients begins in the sanatorium in the form of "occupational" activities, and gymnastic exercises; it continues in "post-curative" establishments where it is soon linked with occupational training. Because of the effectiveness of antibiotics, tuberculosis has practically become an illness like any other and tubercular patients can be cared for in the normal way. But the rehabilitation of "social tubercular" cases still comes up against insuperable medical and professional difficulties.

On the other hand the rehabilitation of cardiac cases, especially victims of coronary thrombosis, is a rapidly developing branch (14). As soon as the acute period of the attack is over, gymnastic exercises are practised (known in France and Belgium as "effort retraining" or physical rehabilitation); the exercises are carefully calculated and stringently supervised. They consist in pedalling an ergometric bicycle, followed by various exercises which are standardized as a function of the energy they require. These activities which amount to thorough "myocardiac functional retraining" can only be followed in a hospital or para-hospital environment.

In some favourable cases they give way to effective occupational rehabilitation, i.e. to gymnastic and workshop activities corresponding to the patient's future occupation determined by vocational guidance. Our experience of this late stage of rehabilitation of cardiac cases is only limited, but we believe the segregation of these patients - which has adverse effects in more than one direction - should cease immediately. As soon as an occupational prognosis has been made, it is preferable to transfer them to a multi-purpose occupational rehabilitation centre, provided that measures of prudence and safety are taken, i.e. stringent physiological and cardiological supervision during the physical activities.

3.3.2. Some industries (e.g. building and public works, mining) join forces to organize the occupational rehabilitation of their staff. Specialized training is given by "occupational group" (15).

This system can be designed with adequate breadth; its form is always specialized by reason of the limited number of jobs for which it prepares patients. It leads to simple placing of patients in subsequent employment. It is not always certain, however, that the disabled person can benefit in such centres from all the possibilities afforded by social legislation on resettlement.

3.4. Occupational rehabilitation within a firm is a priori an excellent system because integration in the given environment is the best means of adaptation. It can be carried out in two ways, either individually through "rehabilitation contracts" between the employer and the responsible authority or collectively in special workshops.

3.4.1. The first solution is adopted by small companies. If the employer has and uses the necessary medical and technical facilities for this rehabilitation the results may be excellent.

3.4.2. The second solution, i.e. that of "special rehabilitation workshops", is better known and a great deal of literature is available on the subject.

The first systems organized in Great Britain and America were designed to receive disabled persons in company workshops during the period of temporary disability resulting from illness or accident. The idea was to replace this period of inactivity and financial difficulty by genuine work and normal wages. In doing so the principal aim was to prevent the "dehabilitation" which results from immobility and isolation from the environment with harmful effects both for the employee and for the company. After this period in a special workshop, the employee generally returned to his original job (16).

The activities organized in the workshops had both functional and occupational aspects. The working movements which the disabled person was required to perform, were designed to correct the local motor anomaly and were not a form of ergotherapy. The general activity of the mind and body (necessarily associated) amounted to occupational rehabilitation.

The systems used at present, at least in France, differ considerably from the original experiments. Disabled employees are rarely admitted to rehabilitation workshops before consolidation of their condition. They have already benefited from functional rehabilitation - or been deprived of it in unfortunate cases - and the doctor has authorized a return to work. The officials in the company agree to the employee's return but, finding a partial disability which results from the after-effects of his pathological condition, they take steps to correct it by occupational rehabilitation. The proposed activities are not specific to the future employment but rather chosen as a function of the disability to be corrected.

3.5. In principle "protected" work in "protected" workshops (meaning that there was public assistance and a public guarantee) was reserved for disabled persons who could not obtain or hold down a job in the normal circuit because of the nature of their disability. These workshops were intended for seriously disabled adolescents and adults suffering from motor, sensorial and mental conditions. Their assignment to a workshop of this kind was permanent or final.

In practise, however, things have turned out differently and most protected workshops are simply a transitional stage after which the majority of disabled sent to them return to the normal employment circuit. Here the disabled are observed and classified; they undergo occupational training and rehabilitation.

This is a less "pure" solution but it is more realistic and probably also more human. It follows therefore that protected workshops often lead seriously disabled persons to workshop activities corresponding to jobs available with specific employers so that the persons concerned can be placed in suitable positions.

3.6. Fairly often the disabled person is not able to return to work because of the serious nature of his physical disability and the lack of suitable occupational training opportunities.

He cannot compensate his physical weakness by acquiring a skill. And since manual activities are too hard for him he is likely to be relegated to a "minor job" which amounts to his downgrading.

For these disabled persons, it is possible to try courses of training as "specialized workers" which are sometimes referred to as "industrial retraining".

These courses do not amount to genuine training because the knowledge and technical skills required are elementary and quickly acquired. But they do not amount to simple occupational retraining either. They are a blend of both methods and a special way of rehabilitating the disabled for employment differing from the systems described earlier. They can lead to highly satisfactory occupational reintegration.

4. Conclusions

Since the second world war there has been a considerable growth in the rehabilitation of disabled persons, because of the increase in the number and severity of cases encountered and also because of the greater desire shown by men to enable their more unfortunate fellows to benefit from the advantages of progress.

Experiments and legal provisions have proliferated and differ from country to country. There has never been a more urgent need for information, comparison of ideas and respect for a given set of principles.

Rehabilitation is a continuous process which leads the disabled individual from the start of his illness or injury to his return to work, i.e. independence. It takes place without interruption from the hospital to the company. The work is first controlled by doctors and their assistants and then by occupational specialists. It is always a complex problem because questions of health, occupational future and social commitment arise at all times with differing degrees of severity (17).

It is essential for the process of rehabilitation to be unified, i.e. all the aspirations, achievements and techniques must be grouped together to allow the disabled person to be reintegrated in society in a job which is suitable for him and to which he is entitled. It implies a common sense of purpose, an integrated organization and a team encouraged by the same ideal.

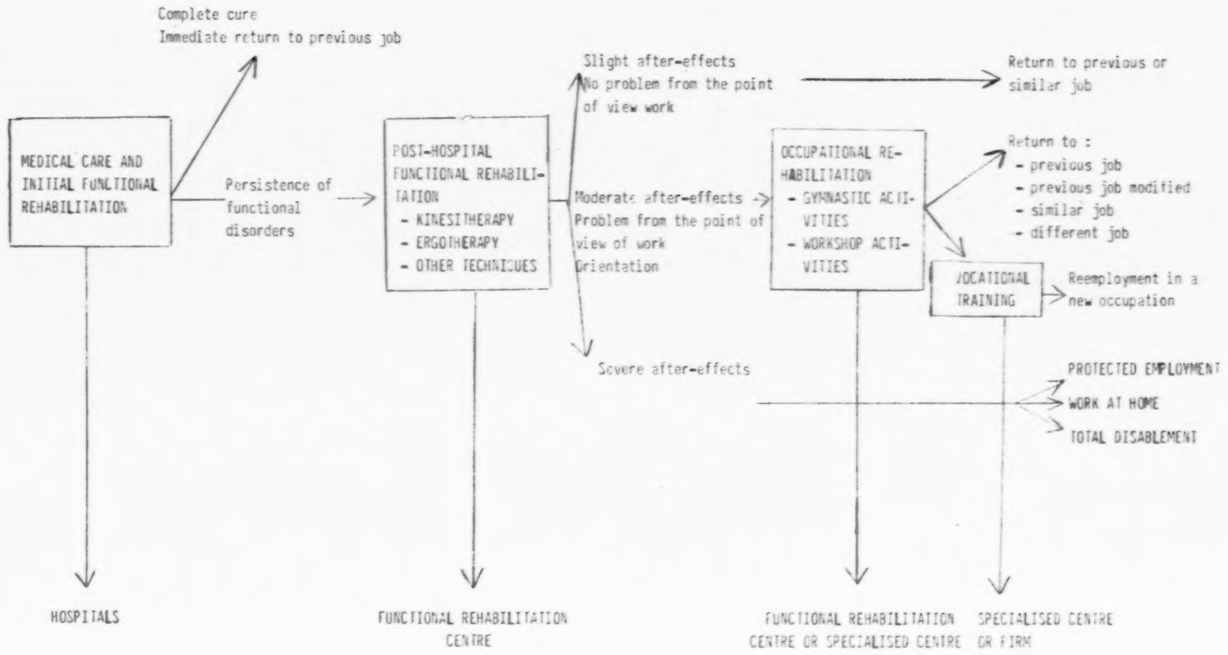
Occupational rehabilitation is not a new process which has taken the place of methods with which we are well acquainted. It is simply a step forward in one aspect of the known process.

Many physically disabled persons cannot return to work after functional or medical rehabilitation as it is practised today, i.e. dominated by concern for the patient's health in a hospital atmosphere, the aim being to correct a local motor deficiency under the supervision of doctors and their assistants. These disabled persons lack strength and resistance and have not learnt how to compensate their disability by new movements.

Simple occupational rehabilitation as an extension of functional rehabilitation often seems the easiest and most reasonable solution. The two means used previously, ie. kinesitherapy and ergotherapy (physical exercise and work), are continued. But their objective is not therapeutic now, ie. to cure the motor deficiency of a member of segment of a member affected by the injury or illness. They now have an occupational and social purpose: to improve the condition of the mind and body so that the patient is able to face the requirements of a normal job.

Depending on the method which predominates, rehabilitation may assume a "gymnastic" or "occupational" form. This variation stems from the environment and persons involved and not from a difference of opinion regarding the basic principles. If it were possible to work out an ideal project we should combine these two methods without restriction or difference, i.e. simultaneous physical activity and workshop activity, as aspects of occupational rehabilitation. The latter in turn would form part of a vast system ranging from medical to occupational rehabilitation.

5. DIAGRAM OF REHABILITATION


Complete cure
Immediate return to previous job
MEDICAL CARE AND INITIAL FUNCTIONAL REHABILITATION
Persistence of functional disorders
POST-HOSPITAL FUNCTIONAL REHABILITATION
- KINESITHERAPY
- ERGOTHERAPY
- OTHER TECHNIQUES
Slight after-effects
No problem from the point of view work
Return to previous or similar job
Moderate after-effects
Problem from the point of view of work
Orientation
OCCUPATIONAL REHABILITATION
- GYMNASTIC ACTIVITIES
- WORKSHOP ACTIVITIES
Return to :
- previous job
- previous job modified
- similar job
- different job
VOCATIONAL TRAINING
Reemployment in a new occupation
Severe after-effects
PROTECTED EMPLOYMENT
WORK AT HOME
TOTAL DISABLEMENT
HOSPITALS
FUNCTIONAL REHABILITATION CENTRE
FUNCTIONAL REHABILITATION CENTRE OR SPECIALISED CENTRE
SPECIALISED CENTRE OR FIRM

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DISCUSSION

G. SCHWARZ

The effect of manual work on the health of juveniles employed in industry is often more dependent on their physical condition than on their type of employment. Medical services must therefore ensure that handicapped persons and juveniles with physical disabilities are not placed in occupations where their health might be endangered.

Physical development requires the continuous application of adequate stimuli, particularly of a physical kind through periodic muscular exercise. That is why every legislature is anxious to ensure that firms organise theoretical and practical training courses for juveniles, wether engaged as apprentices or young employees, in order to eliminate movement-deficient work and excessive strain during attendance which might hamper their development.

To determine wether a juvenile's physical development and hence his health is affected by a particular job, it is necessary to establish wether he is employable in the first place. About 10 per cent of all school-leavers are unsuitable for manufacturing industry and mining on account of their physical development, the reasons for their being rejected varying from year to year. This finding is based not only on clinical tests; it also takes into account the kind of work load - which implies predetermined work standards - to which juveniles have to be subjected in order to provide powerful stimuli to development through manual work without any consequent risk of the growing organism being damaged.

Investigations into juveniles employed in industry have shown that symptoms of fatigue or exhaustion occuronly among retarded juveniles, i.e. among juveniles whose general development diverges from the mean frequency distribution. Types of work which produce manifestations of excessive strain in retarded persons are absolutely essential for the training and further development of all others of the same age.

Experience also shows that retarded as well as precocious juveniles are more than usually subject to general postural disabilities, heightened circulatory stress at rest and accentuated proneness to disease. Though juvenile workers in industry and mining are in short supply, it is essential for them to undergo special physical screening if their health and development are to be safeguarded and their training properly conducted.

In order to prevent developmental disorders, the prophylactic examinations required under the Juvenile Workers Protection Act are supplemented in many firms by post-entry examinations and regular check-ups. These examinations are related for the most part to a particular type of job, and are normally carried out by works or company doctors. There are also worker protection regulations under which prophylactic examinations and check-ups are prescribed wherever juveniles or even adults have to undertake work constituting a health hazard. In the mining industry, for example, juveniles have to undergo medical check-ups at specified intervals; they must also be re-examined at every change in their working environment, e.g. when they start working underground.

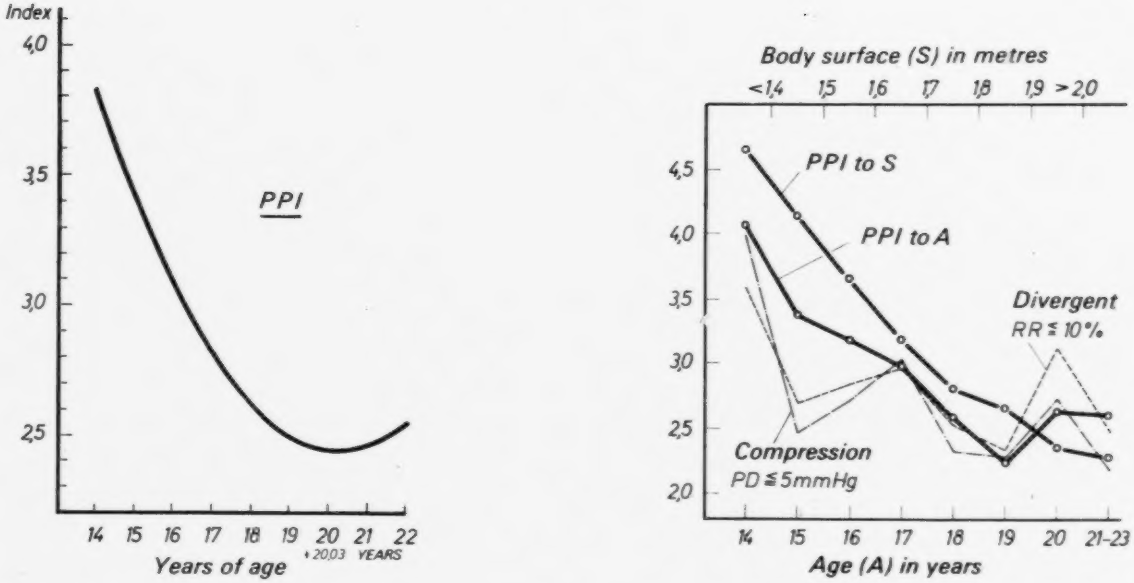
For the purpose of excluding handicapped juveniles, all industrial firms will in future apply fitness tests to determine wether an individual's fitness is up to standard, how far he fits into a particular performance category, and wether the fitness of an adolescent already matches that of the adult. Such fitness tests, largely derived from sports medicine, are primarily concerned with physical fitness, placing less emphasis on dynamometric measurements of motor functions than on ergo-spirometric measurements of heart-circulation activity and of ventilation functions at rest and under stress. Since even in the field of youth employment, however, industrialisation and automation are tending to diminish the importance of general physical requirements at the expense of psychological stress, a necessary additional criterion of a person's fitness is his psychological resistance.

Apart from fitness tests, the protection of specially handicapped juveniles also calls for steps to control the amount of physical and psychological strain involved in job performance. Experience shows that measurements here are best extended beyond more than one shift. But since adolescents frequently manifest symptoms of strain as a result of some organ system having to work harder than others, continuous automatic measurements of pulse frequency and blood pressure are not enough, but have to be supplemented by pneumometric and gas-analytical measurements as well as by measurements of body temperature. It is also necessary to apply psychological measuring procedures at the place of work to detect any fatigue impulses by which psychomotor functions might be impeded.

Handicapped juveniles employed in manufacturing industry or mining whose physical and psychological development differs from that of other juveniles, or is likely to be retarded even on reaching adult age, interfere with the training of other juveniles on account of the special consideration which their physical condition demands. Such juveniles, who in industrial firms with fixed physical requirements have to be classified as inefficient, often prove their ability to hold their own in other firms to which this classification does not appertain.

Methods and criterie

Fitness tests, relayed to the moving platform, have shon that youths of 14 to 16 years of age are suitable for industry if they are able to keep walking on a moving platform for 30 minutes at a speed of 60 m per minute without showing significant circulation strain. The same applies to 17- to 19-year-olds with the belt speed accelerated from 60 to 100 m per minute. In addition to horizontal walking, the platform can also be used for 15-minute spells of movement on a 3 per cent gradient, with the belt speed again set at 60 m per minute for 14- to 16-year-olds and at 100 m per minute for the older age group.



Figs. 1 and 2

To assess physical fitness, particularly of youths, a work-out on the bicycle ergometer at progressively increasing load, preferably using the performance pulse index (PPI) according to E.A. MULLER, may be recommended. A given PPI may be demanded of youths of any age. Not all of them exhibit a normal rest pulse; blood pressure should also be measured, since 14,7 per cent of 14- to 15-year-olds and 9,4 per cent of 16- to 20-year-olds have been found to manifest blood pressure changes, with a correspondingly lower pulse frequency, producing a better PPI than their actual fitness indicates on other grounds.

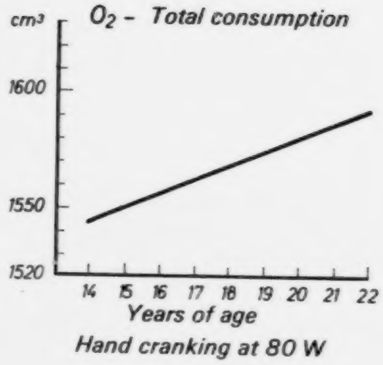


Fig. 3

One spiro-ergometric load test which has well proved itself among youths is crank machine work with an output of 80 W, equivalent to a medium-heavy continuous load experienced during one shift and hence a recognised standard of comparison to be used in conjunction with relevant respiratory and pneumometric measurements at the place of work. This can be used for measurements not only of O_2 consumption and CO_2 emission but also of circulation; ECG tests are, however, better carried out by means of bicycle pedalling in a lying position.

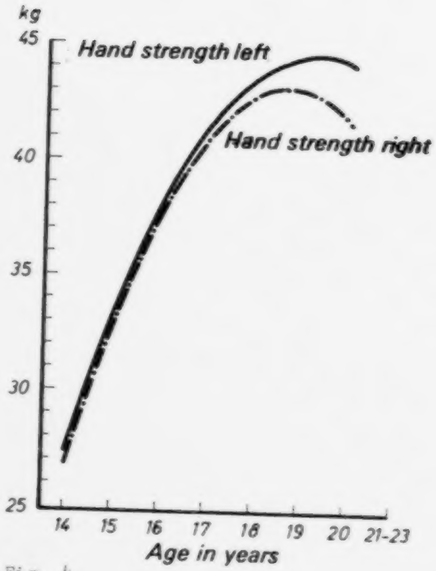


Fig. 4

Hand strength. Dynamometric measurement of muscle strength development in juveniles is often required for the assessment of standards. Thus during the last ten years the muscle strength of youths employed in mining and manufacturing industry has averaged 63 per cent of the maximum at 14 years of age, 67 per cent at 15, 84 per cent at 16, 90 per cent at 17, and 93 per cent at 18.

When chronically - but not visibly - disabled persons, such as many of those recovering from a chronic internal disorder or major surgical operation, are to be rehabilitated, special procedures are called for.

In the first place, the extent of their disability may all too frequently still be incapable of adequate assessment, and the duration of clinical treatment or of a suitable substitute may be incalculable, while the effects of both on actual performance may not be detected and hence accomodated by the outside world.

Again, any interruption of the long-term process of occupational and social adjustment on account of sickness is bound in due course to involve the reintegration of those concerned in difficulties which might endanger their rehabilitation in the end,

Fig. 1

If a person will still fully recover from a brief illness unaided, he or she will do so from a protracted one only with additional help. But if the need for the earliest possible efforts to overcome any remaining barrier to adjustment is not recognised, and if it is preferred to leave these to the person's own initiative or to undertake them, if at all, only spasmodically from case to case, the result will be equally unsatisfactory.

The present gap between the resources of medicine and the requirements of an advanced industrial society can therefore be bridged only if rehabilitation proceeds by progressive and carefully integrated stages (Fig. 2).

These should be designed, at the earliest opportunity after the acute stage of an illness, to supplement any further clinical treatment with measures of physical and psychological resuscitation, to place the patient's entire organism under a progressively increasing load, and thus to involve him or her, collaborating as an equal partner with outside experts, in working out a tailor-made rehabilitation plan which should be implemented and carried towards a productive end, as soon as medical circumstances permit, by making good any technical deficiences, mobilising any latent abilities and taking whatever further preparatory steps may be required.

Fig. 3

An institution concerned with such progressive rehabilitation must therefore proceed on the basis of a whole range of organically related procedures.

Basically, if medical or other imponderables permit more than just social integration and obviate the need for continuous nursing, there are five different procedures whereby, either through simple training or through concentrated preparation for work, the previous or a suitable new job or else an alternative occupation can be brought within reach.

Fig. 4

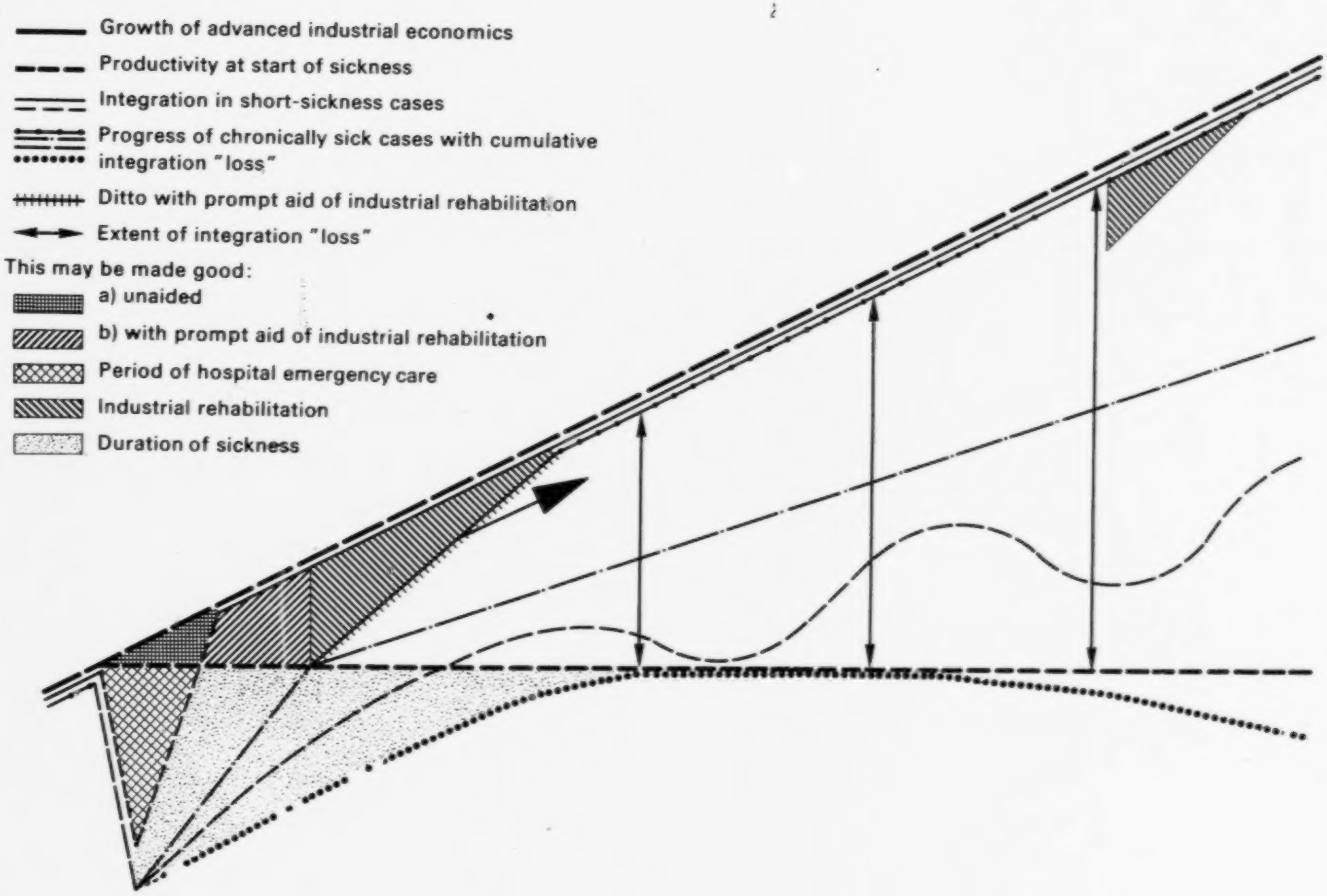
As the example of our centre shows, the organisation of such a half-way house between prolonged illness and satisfactory rehabilitation has not only to take equal account of the medical and occupational side, but also, in the patients' interest, to offer maximum scope for flexibility.

Fig. 5

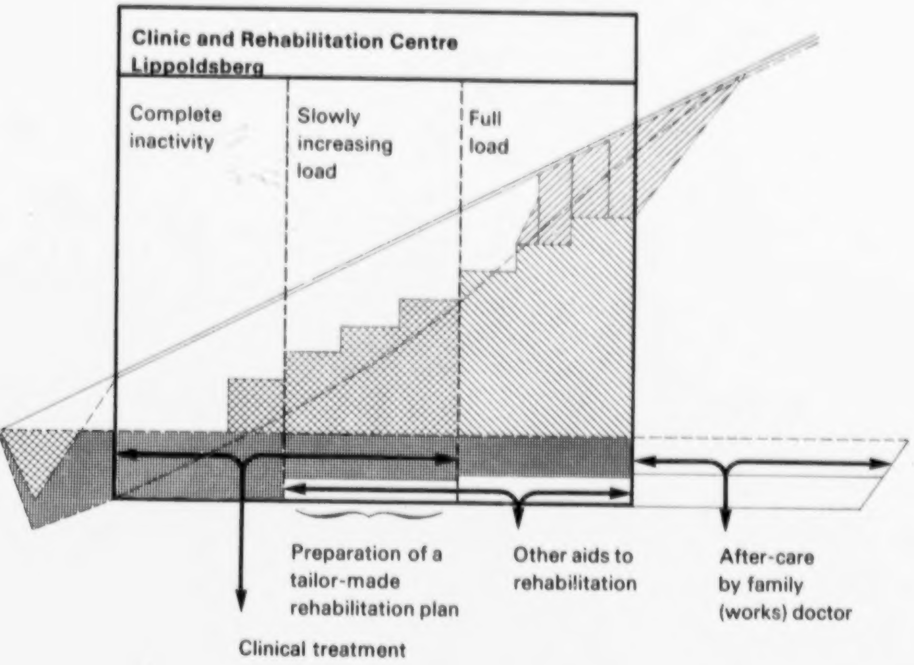
Thus, of 500 disabled juveniles, we managed to place 187 in a suitable permanent job by means of resuscitation alone and to find productive new employment for the rest through retraining in our own centre or elsewhere.

Of course, such success in rehabilitation depends on a well organised, constructive system of liaison between different disciplines (Fig. 6), which our centre also en-

Integration "loss" in the treatment of the chronically sick


Growth of advanced industrial economics
Productivity at start of sickness
Integration in short-sickness cases
Progress of chronically sick cases with cumulative integration "loss"
Ditto with prompt aid of industrial rehabilitation
Extent of integration "loss"
This may be made good:
a) unaided
b) with prompt aid of industrial rehabilitation
Period of hospital emergency care
Industrial rehabilitation
Duration of sickness

"Bridging" devices for making good the integration "loss" suffered by the chronically sick



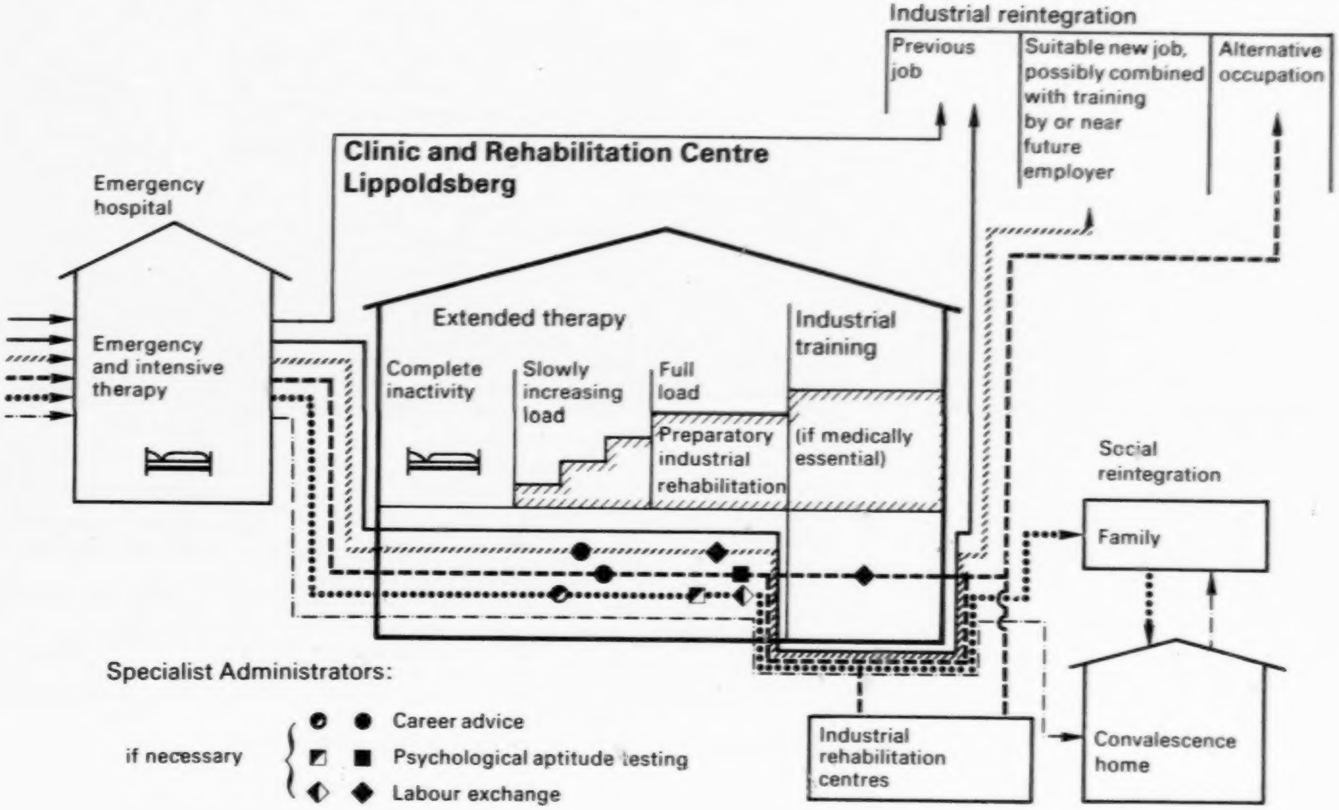
Clinic and Rehabilitation Centre
Lippoldsberg
Complete inactivity
Slowly increasing load
Full load
Preparation of a tailor-made rehabilitation plan
Other aids to rehabilitation
After-care by family (works) doctor
Clinical treatment

▨ Qualifying further education special training

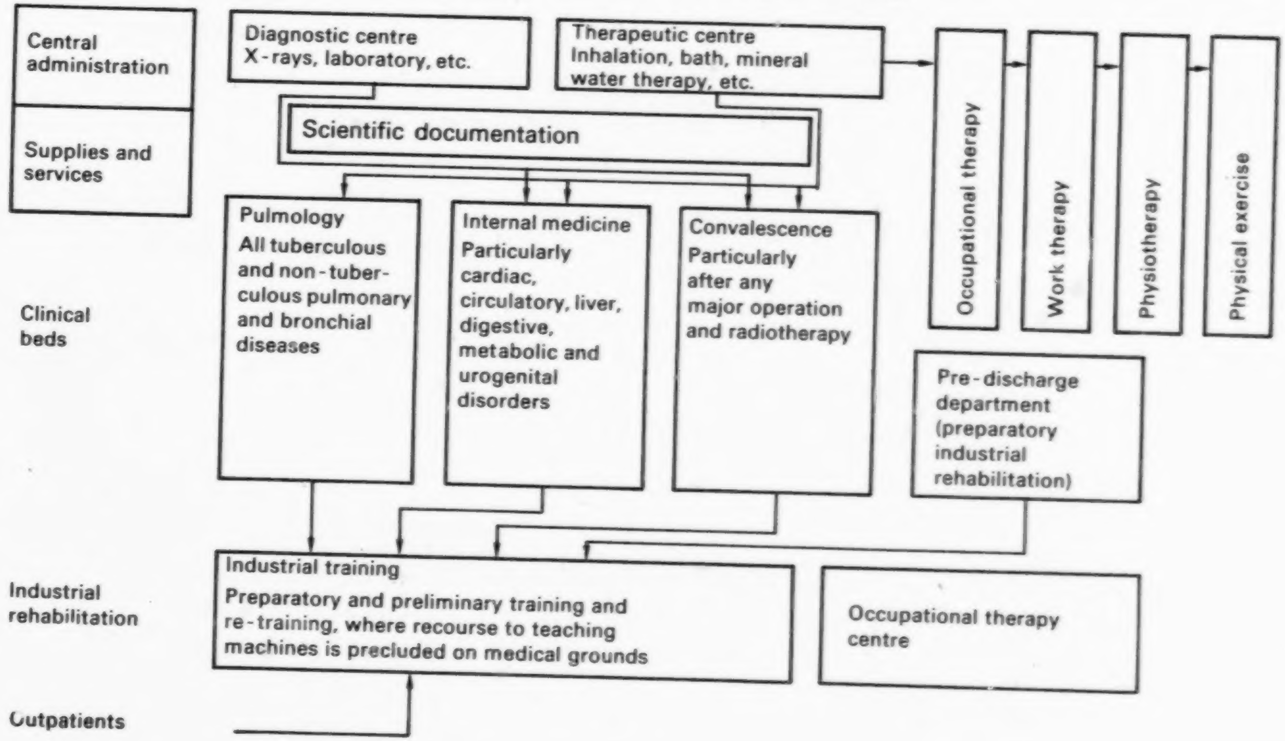
▨ Industrial rehabilitation making good technical deficiencies

▦ Random rehabilitation Psychological and physical resuscitation

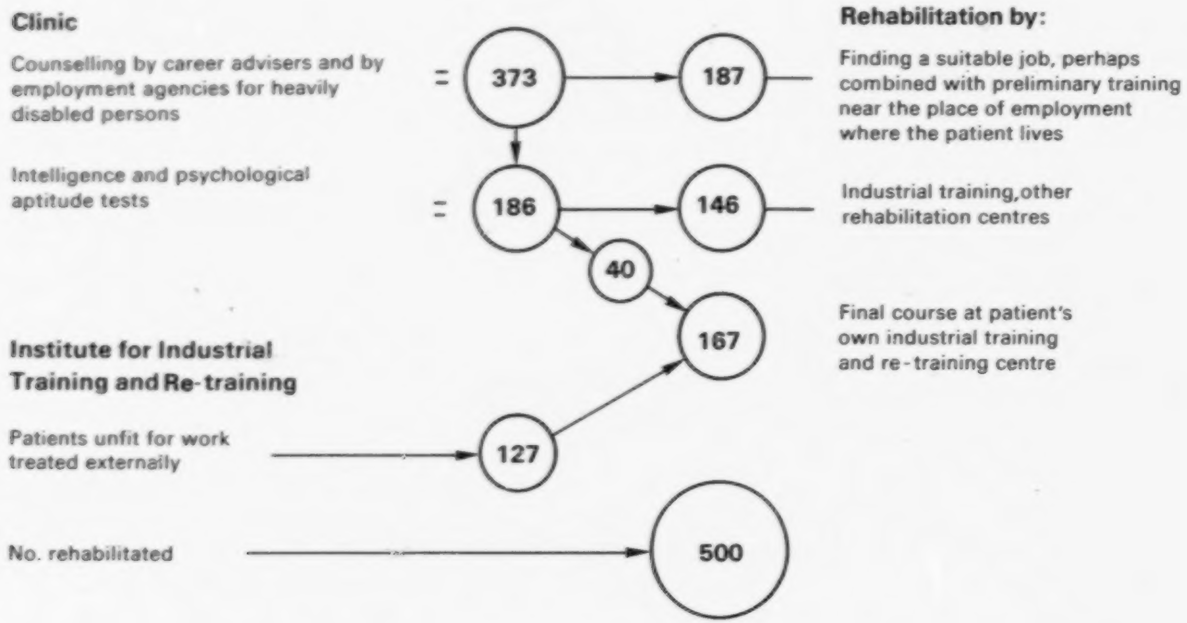
Reintegration model for the chronically sick


Industrial reintegration
Previous job
Suitable new job, possibly combined with training by or near future employer
Alternative occupation
Clinic and Rehabilitation Centre Lippoldsberg
Emergency hospital
Emergency and intensive therapy
Extended therapy
Complete inactivity
Slowly increasing load
Full load
Preparatory industrial rehabilitation
Industrial training
(if medically essential)
Social reintegration
Family
Convalescence home
Industrial rehabilitation centres
Specialist Administrators:
if necessary
Career advice
Psychological aptitude testing
Labour exchange

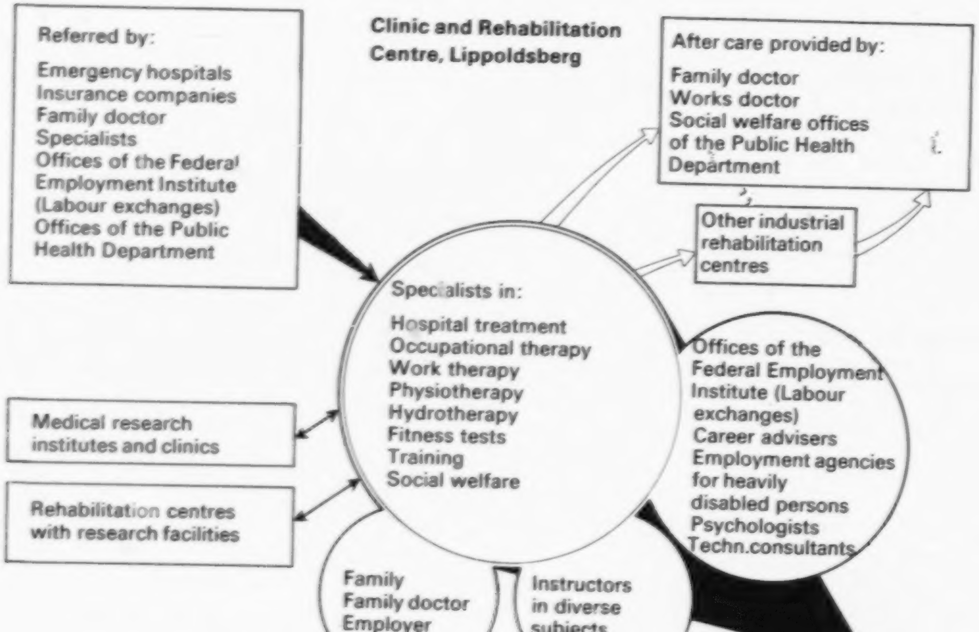
Organisation chart of
Clinic and rehabilitation centre, Lippoldsberg


Central administration
Supplies and services
Clinical beds
Industrial rehabilitation
Outpatients
Diagnostic centre
X-rays, laboratory, etc.
Therapeutic centre
Inhalation, bath, mineral water therapy, etc.
Scientific documentation
Occupational therapy
Work therapy
Physiotherapy
Physical exercise
Pulmology
All tuberculous and non-tuberculous pulmonary and bronchial diseases
Internal medicine
Particularly cardiac, circulatory, liver, digestive, metabolic and urogenital disorders
Convalescence
Particularly after any major operation and radiotherapy
Pre-discharge department (preparatory industrial rehabilitation)
Industrial training
Preparatory and preliminary training and re-training, where recourse to teaching machines is precluded on medical grounds
Occupational therapy centre

Rehabilitation, jointly with the federal employment institute (AA Kassel), of patients liabie to permanent disability or unfit for work


Clinic
Counselling by career advisers and by employment agencies for heavily disabled persons
=
373
187
Intelligence and psychological aptitude tests
=
186
146
40
167
Institute for Industrial Training and Re-training
Patients unfit for work treated externally
127
No. rehabilitated
500
Rehabilitation by:
Finding a suitable job, perhaps combined with preliminary training near the place of employment where the patient lives
Industrial training, other rehabilitation centres
Final course at patient's own industrial training and re-training centre

Liaison between different disciplines


Referred by:
Emergency hospitals
Insurance companies
Family doctor
Specialists
Offices of the Federal Employment Institute (Labour exchanges)
Offices of the Public Health Department
Clinic and Rehabilitation Centre, Lippoldsberg
After care provided by:
Family doctor
Works doctor
Social welfare offices of the Public Health Department
Other industrial rehabilitation centres
Specialists in:
Hospital treatment
Occupational therapy
Work therapy
Physiotherapy
Hydrotherapy
Fitness tests
Training
Social welfare
Offices of the Federal Employment Institute (Labour exchanges)
Career advisers
Employment agencies for heavily disabled persons
Psychologists
Techn.consultants
Medical research institutes and clinics
Rehabilitation centres with research facilities
Family
Family doctor
Employer
Instructors in diverse subjects

joys in full measure.

Progressive reintegration demands completely open-minded co-operation between those responsible for referring and rehabilitating actual cases, on the one hand, and after-care welfare services, on the other. And it is only through the active collaboration of rehabilitation officers, instructors, members of the family, doctors and labour market-oriented employers that all the available means of rehabilitation subject to proper concern for medical needs can be effectively utilised.

This includes, of course, a continuing interest in medical advances as well as in improved methods of training.

Here, the research facilities and institutions which have already been set up specifically for rehabilitation are most encouraging pointers for the future.

But the real break-through will only come with systematic research into improved methods of treatment and more sophisticated criteria of evaluation, with more intensive co-operation in the fields of clinical and industrial rehabilitation, and with still closer integration of the entire spectrum of rehabilitation, training and further education to the benefits of patients and the community alike.

M. LENOBLE

The place of sociology in the process of rehabilitation.

The various disciplines normally associated with rehabilitation are rehabilitation medicine, psychology, psychotherapy, kinesitherapy, ergonomy, etc. Sociology is all too often forgotten. For in sociological theory the group consisting of disabled persons comes under the heading of deviancy. The stigma of disablement militates against social acceptance. This stigma comes into being, according to Erveigg GOFFMAN, through the contrast between the real identity, that is, the identity which the disabled person can actually claim, and the virtual identity, namely that which is attributed to him by others. Sociology thus comes into play at the level of the transitions from one milieu to another, for instance, the transition from a rehabilitation milieu to that of society as a whole, the family and the environment, or from a sheltered workshop to a normal workin organisation. Furthermore, sociology also plays a part in the designing of the organisational structure of the various therapeutic institutions with a view to reducing the structural distortions between these and society as a whole.

F.B. VENEMA

A comment regarding points e) and f) of the summary.

Point e): The establishment of the greatest possible number of centres or institutions specialising in functional and industrial rehabilitation. In my opinion this statement does not allow sufficient latitude and would be more likely to lead, in its extreme form, to the alienation of rehabilitation from treatment in hospitals, where after all a large proportion of our medical treatment takes place.

Hence what we need above all is development of rehabilitation in the hospital and, depending on the requirement which develops afterwards, establishment of specialised centres in close association with, more often than not, a group of the afore-mentioned hospitals.

This also provides a sound basis for the integration of rehabilitation since, if rehabilitation is also developed in the teaching hospital, better opportunities are created for training in rehabilitation.

Lastly, a further comment in connection with the speciality of rehabilitation. In the European context we know two forms of this: firstly rehabilitation as a qualification ("compétence") and, secondly, rehabilitation as a separately recognised speciality, as, for instance, in the Netherlands, with a four-year training course, this speciality enjoying the same recognition as, for instance, surgery or internal medicine.

I believe that the existence of an independent speciality of rehabilitation can both make a contribution towards better integration of rehabilitation and also promote training in rehabilitation within the framework of normal medical education. For instance, the Netherlands now has lectureships in rehabilitation with their own syllabuses at four different universities.

M. CESA-BIANCHI

I agree with the substance of the GERUNDINI-HOUSSA paper and also on the importance of group activities and continuing professional guidance, emphasised in the PIERQUIN-STORM paper. To supplement these, I think it necessary to mention the following points:

1) Rehabilitation medicine, which must begin its work at a very early stage, plays a secondary preventive function in relation to the damage - at one time

regarded as inevitable - persisting as a permanent result of a lesion. But this extremely useful function must be continuously linked with primary prevention, that is, with preventive measures against the accidents and diseases which cause the lesions.

2) Rehabilitation must apply not only to the disabled person but also to his family, which is often indirectly affected by what has happened to one of its members, and can prove an obstacle to his rehabilitation.

3) The handicap is not necessarily physical but may be psychic (intellectual deficiency, emotional disturbances, etc.) or social; and even when it is physical, it has a psychological and social component which must be taken into account in rehabilitation.

4) Influence must be brought to bear not only on the disabled person and his family but also on society to induce it to change its prejudices and to encourage positive attitudes to the resettlement of the disabled person.

5) The resettlement of the disabled person in a job should include - if necessary - ergonomic adjustment of the job itself to the potentialities of the disabled person.

N. COOPER

The two speakers have quite rightly emphasized the need for medical rehabilitation to be included in the curriculum of training in medical schools. I respectfully suggest that such training should provide for an insight to be given to medical students into the basic principles of vocational rehabilitation. This can be done in one of several ways:

i) through specific lectures given by vocational rehabilitation specialists;
ii) visits by medical students to local industry to see the actual conditions of work which disabled persons may eventually have to face;
iii) detachment of students for short periods to work alongside the medical officer in a vocational rehabilitation centre.

The latter method is particularly effective, for we have found that these same students, on graduating and taking up work, as general practitioners or hospital doctors, have conscientiously referred their patients to vocational rehabilitation services, simply because they were fully aware of the invaluable help and assistance such services could offer.

N. COOPER (2)

The speaker was kind enough to refer to the pioneering role of the International Labour Organisation in the field of vocational rehabilitation, particularly insofar as the formulation of international standards and guidelines on this subject are concerned. I thought it might be helpful if I were to quote to you the relevant definitions in ILO Recommendation 99 which provide a firm basis for vocational rehabilitation programmes, viz:

1) The term vocational rehabilitation means that part of the continuous and coordinated process of rehabilitation which involves the provision of those vocational services e.g., vocational guidance, vocational training and selective placement, designed to enable a disabled person to secure and retain suitable employment.
2) The term disabled person means an individual whose prospects of securing and retaining suitable employment are substantially reduced as a result of a physical or mental impairement.

3) Vocational Rehabilitation services should be made available to all disabled persons, whatever the origin and nature of their disability and whatever their age, provided they can be prepared for, and have reasonable prospects of securing and retaining suitable employment.

G. CRAVIOTTO

It is thought that in recent years theory has advanced further than practice. Indeed, observing as a layman the photographs showing the rehabilitation exercises of disabled persons I have gained the impression that technology has not provided much aid to rehabilitation in recent years.

There is also the problem of the staff engaged in the re-education of disabled persons. It is true that the doctor is unable to chose the subjects for the re-education course, but it should be possible to select those who will look after the recovery of the disabled person.

The staffs of rehabilitation centres should not only have theoretical knowledge but should also be sufficiently acquainted with the working environment to be able to follow, psychologically as well as in other respects, the re-introduction of the disabled person into the production process.

C. AMOUDRU

It seems to me useful to emphasise the importance and effectiveness of medical rehabilitation by giving an actual example.

Shortly after the last war, Charbonnages de France created several functional rehabilitation centres. The largest is the rehabilitation centre at OIGNIES, Pas-de-Calais; this has 80 beds and receives mainly victims of industrial accidents involving the personnel of the

Houillères du Bassin du Nord et du Pas-de-Calais (Coalfields of the North and Pas-de-Calais basin).

Now it is our custom to follow the vocational development of resettled persons and in particular to examine their long-term development, which is more significant than the immediate result after they leave the centre. Out of 1,500 persons who attended the centre after a serious or moderately serious mining accident, the results after five years are as follows:

60% have resumed their previous work underground;
30% are underground but are benefiting by a redesigned job;
5% have been resettled in light work above ground;
5% only have requested release owing to disablement.

R. FRANCOIS

I should like to make a simple statement:

I represent: l'Union Nationale des Associations de Parents d'Enfants Inadaptés and la Ligue Internationale d'Aide aux Handicapés Mentaux (the National Union of Associations of Parents of Maladjusted Children and the International League for Aid to the Mentally Handicapped).

I thought, when I came to this symposium, that mention would be made of the problems connected directly with the mentally handicapped.

We were told this morning that, in view of the importance of the problems to be discussed and the questions raised, it had been necessary to limit the choice of subjects.

I would merely ask the Organising Committee not to eliminate this particular aspect from its considerations, even if it cannot deal with it during this symposium. I express the wish that, if necessary, thought should be given to the organisation of a meeting devoted specially to mentally handicapped adults in the Community countries. Furthermore, I am also acting as the spokesman for a small group of participants in order to urge that a meeting between participants interested in this specific problem be arranged, possibly outside the programme of this symposium.

V. GUARDASCIONE

I share the view stated by my colleague GERUNDINI: rehabilitation - in order to overcome the anxious state of distrust and discouragement - must take place very early. That is, it must start in the hospital phase or, at the latest, in the post-hospital phase. In order to achieve this aim, however, the work of the psychologist, of a highly qualified medical and paramedical staff, and of the various practices of physiokinesitherapy and ergotherapy are not sufficient without the cooperation of the disabled person. We consider that good results can be obtained only if we succeed in giving the disabled person an incentive, by giving him the certainty that, when he has been rehabilitated and vocationally retrained, he will be able to find re-employment suited to his restored ability to work. Working activity must of necessity be resumed. There is nothing worse than for a disabled person, rehabilitated and retrained, to remain inactive and thus socially unproductive. We some time ago asserted this principle, which incidentally is new, when we were concerned with the prevention of disability.

Prof. PIERQUIN mentioned, among other things, the retraining for work of tubercular persons. What he said is confirmed by our experience in ourconvalescent homes for sufferers from silicosis. We have in fact found that if these persons remain unoccupied and only undergo climatic and aerosol cures, the resumption of work, on completion of recovery, is always very painful, rather as if the rest had impaired their aptitude for work, upsetting the still precarious balance of the cardio-respiratory function. This was not found, on the other hand, when the silicosis sufferers were also subjected, during their stay in hospital, to respiratory gymnastics and ergo-therapeutical exercises.

Prof. PIERQUIN made the point regarding the terms "readaptation", "requalification", "rehabilitation", "re-education", etc., which are sometimes used indiscriminately and wrongly. We fully agree with what he said.

With us in Italy the expression "rehabilitation" implies a concept which refers only to practices designed to restore and improve the anatomo-functional state, while the expression "re-education" refers only to the phases of learning and readaptation to a new trade.

What Prof. STORM said in particular about chronic heart and lung sufferers is very interesting. Our experience of the subject derives from what we are doing and the aims we are promoting in connection with the rehabilitation of silicosis sufferers. These, as is well known, are persons with a precarious cardio-respiratory function resulting from anatomical conditions which show a marked tendency towards deterioration. In these cases, unlike that of persons with disabling illnesses of a surgical nature, it is difficult to foresee what results can be produced by rehabilitative therapy and whether such results will - within reasonable limits, of course - be more or less permanent.

We have, however, found that there is no possibility of establishing correlations between the recovery of the cardio-respiratory function and the types of work to which these patients - as a result of this recovery - can be assigned.

OCCUPATIONAL TRAINING OF THE DISABLED

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REPORTS

M. MUTTERER

Introduction

Occupational training is one aspect of the occupational rehabilitation of disabled persons. Its aim is to enable them to return to a normal active life.

For this to be possible, the training programme must be based on an objective analysis of the condition of the disabled individual and of the means available for his rehabilitation.

Occupational training of the disabled calls - to a greater extent than any other form of vocational training - for a progressive strategy coupled with the use of new organizational, informational and teaching techniques.

Only in this way can the action which is taken be effective and equality of opportunity ensured for the disabled.

I. Foundations and limits of occupational training programmes for the disabled

The person who attempts to give disabled persons equal opportunities with other workers is not embarking on a game of chance but carrying out a realistic programme based on precise information on the persons concernedm their disability, occupational and educational background and motivation.

It is also necessary to consider which method and procedure of occupational training is most suitable in the given individual case. Finally the technical and economic realities of the present time must be taken into account where possible in conjunction with foreseeable developments.

1. The disabled person and equality of opportunity

1.1. The disability

The choice of an occupational training programme is limited by the disability. There have naturally been exceptional successes: such as the arc welder who has lost both hands or the blind man who repairs radio and television sets. These and other examples which have been quoted too often have been a source of discouragement and new frustration to many. Let us not delude ourselves: disabilities exist and the consequences of accidents or illness are becoming increasingly serious. Industry still has its tiring occupations and obstacles to the development of personality.

From the existing range of occupations we must choose those which will be suitable in the greatest number of cases, bearing in mind the following requirements:

Occupation:
- seated or seated upright
- without excessive horizontal or vertical movement
- without the need to carry loads
- with fixed and regular working hours
- involving not more than 40 hours work each week
- with a clean and quiet working environment
- with normal, correctly planned working rates and speed.

This may seem a lot to ask, but it is essential not to overlook these conditions. Are we entitled to give the disabled occupational training which presupposes specially arranged working positions and conditions of employment which could only be met in exceptional cases? In addition we must not forget that the purpose of occupational training is to reintegrate the disabled person in a normal, active life. The latter entails a certain amount of travelling and very often architectural barriers which have to be overcome.

The limits imposed by the disability itself are linked with another condition: in the sphere of rehabilitation, occupational training presupposes the existence of a job, an apprenticeship or, at least for young people, a vocation.

1.2. The social and occupational environment

In which social and occupational environment is specially adapted occupational training or retraining necessary? Up to now the liberal professions and executive posts have not been affected while technicians and supervisors are rarely involved. Illness and accidents deal a heavy blow against the professional life of manual workers. In very general terms we must accept the fact that unskilled workers, specialized and even skilled employees have only limited or underdeveloped skills; their technical knowledge is non-existent or incomplete and their schooling inadequate or forgotten so that further training or adaptation will be necessary.

The choice of training and above all its technical level are therefore limited. Occupational training programmes for disabled persons generally fall within the following classification brackets (classifications recently adopted in France):

specialized worker (class Va)
skilled worker)-- (class V)
technical employee)
technician (class IV).

In spite of the measure of lattitude allowed in the case of disabled persons, the time available for such training prevents several different levels from being crossed in a single training period.

But the training programmes must be designed in such a way that there is a possibility of further promotion for those who have the intellectual ability and willpower required. The more general introduction of continuous training and vocational advancement programmes should therefore enable more disabled persons to reach higher levels of attainment.

1.3. Age - sex - nationality

The limits outlined above are further complicated by requirements of age, sex and nationality. These requirements are not specific to disabled persons and arise in the context of all occupational training programmes, especially for adults.

The admission of disabled persons over the age of 45 to occupational training courses is not in contradiction with the limits referred to above. It is mainly complicated by certain prejudices which seem paradoxical at a time when lifespans are becoming longer.

Again we often find that occupational training programmes available to women are inadequately developed in our countries. The difficulty to overcome here is similar to that arising from the social and occupational origins of disabled persons. But it also arises from the prejudice that "the woman's place is in the home" - especially if she is ill or infirm, in which case she will be left with light household duties.

Foreign (migrant) workers often have no occupational skills while their educational level is low and they frequently do not know the language of the country in which they are working properly. These workers are condemned to

cial and class segregation; the investment necessary for
eir occupational retraining is considered too high and they
e repatriated. This is a socially injust measure.

The limitations inherent in the condition of the dis-
bled person are very often complicated by the limits im-
sed by our society.

1.4. Legislation

Nevertheless, throughout its history our society has
rked out systems to solve the problems of illness and dis-
bility. Today charity, assistance, mutual support and pro-
dent arrangements coexist in a state of considerable con-
sion and undermine the objectives of occupational training
r the disabled.

The differences between insurance or assistance systems
in the financial arrangements, categories covered and type
aid given - are themselves a source of inequality. But
ven greater inequalities stem from legal provisions which
ke into account the circumstances of the disability rather
an the disability itself.

The complexity of the legislation surrounding each
stem makes it difficult to understand and leads to ad-
inistrative slowness. Poor information, long and complica-
ed administrative procedures, inequality and prejudice
arcely favour the "motivation" about which we hear so much.

The measures now being taken in France to harmonize
cupational training programmes available to the disabled
ould make for greater equality of opportunity.

2. Occupational training methods

The methods of occupational training are so varied that
rmonization is undoubtedly necessary. This is the only
y of ensuring that occupational training can be given to
l disabled persons and jobs found for them.

Access for disabled persons to the different methods of occupational training is dependent not only on the limits analyzed above but also on the limitations inherent in the structure of the different occupational training organizations.

2.1. National education

The technical schools run by the French Ministry of Education (public education) are the ideal solution for all who believe that disabled persons should not be segregated. But, even when the possibility of education of this kind exists, we must recognize the fact that segregation occurs within the structures of the establishment ("special classes"). Perhaps this state of affairs may be even more frustrating to the disabled person.

In addition the barriers of age, selection and training periods are realities as are the staircases which are found in most school buildings of this kind. Moreover these schools do not yet have the pluridisciplinary teams which are particularly necessary for the education of disabled persons.

2.2. Adult occupational training

Occupational training courses for adults with appropriate objectives of conversion, retraining and vocational advancement have identical limitations in their structures and practical arrangements, in particular selection, course timetables, fatigue added to the normal working day in the case of evening classes and the lack of medical, psychological and social assistance.

2.3. Training in a firm

Training in a firm in the form of an "occupational reeducation" contract or in the context of occupational training courses organized by the employer is considered by many as the best method. The arguments put forward in support of this method are the rapid return to "real life" - which is an important psychological and social factor -

and the low cost to the public authorities.

But this method of occupational training, provision for which is laid down in the legislation of most of our countries, has not been widely used, for the following main reasons:

- occupational retraining is not the primary aim of the firm;
- vocational training is confined to the requirements of the individual firm;
- a special form of payment is made; this is frustrating in a normal environment;
- there is no medical, psychological and social assistance or educational aid.

2.4. Training by correspondence

Training by correspondence is another method of occupational training which might seem particularly suitable for disabled persons. Unfortunately it has serious drawbacks. Everyone knows that it is very difficult for an individual to work on his own. Occupational training also entails practical work which cannot always be followed and supervized by correspondence. When this type of training is given by State organizations or bodies under State control, it once again raises the problems inherent in this method of education.

However, it does at least offer a guarantee of serious intentions which is not the case with the many profit making establishments active in the correspondence course sector. Their proliferation and abuses to which they give rise have recently given cause for concern to the authorities in our countries. Disabled persons are ready-made targets for these dubious concerns which make money by selling illusions.

On the other hand certain benevolent organizations established to prepare sick and disabled persons for examinations or vocational training deserve to be encouraged and developed. They have the advantage of not claiming to give complete vocational training but merely of providing a preparation; in addition they offer a service throughout the year at little or no cost. These are specialized establishments - in other words they are adapted to the requirements of individual students.

2.5. Specialized establishments

Do specialized establishments always offer that advantage? It would seem that the segregation for which they are criticized could be avoided if the age, sex and nature of the disability were not themselves specific. A number of occupational training centres for disabled persons now have sufficient experience to prove that a mixed formula is well founded from every point of view.

It is true that a system of this kind requires a fairly large establishment and a pluridisciplinary medical team working either full time or visiting the centre at regular intervals, as well as a larger staff of nurses, paramedical assistants and social workers.

But a large group is not necessarily dehumanizing if it is well organized. And occupational training must be freed in large measure from the protective emphasis, although a measure of protection will always be inherent in the collective life and medical, psychological and social assistance which must be given to students.

The teams staffing specialized occupational training centres require qualities of imagination and a spirit of research. They must be particularly well informed on professional outlets, and the technical requirements of particular jobs; they must also have the necessary equipment to perform their task. The aim of their work is to enable disabled persons to return to active jobs; the consequences for the disabled individual and the public authorities alike would be serious if this aim is not achieved.

3. Jobs and the choice of training methods

Technical progress is making it easier to achieve this aim.

3.1. New jobs

The development of electronic engineering, data processing and mechanical engineering is generating new jobs which are particularly suitable for the disabled. Jobs are becoming available to them in certain industries where automation of the production process is eliminating unpleasant and tiring activities. The new industries also have the advantage of requiring skilled personnel with different levels of qualification in a given technological sector. Disabled persons are therefore able to find posts which match their level of knowledge and gain advancing as a function of their aptitude in the technical branch they have chosen.

However, the rapid advances in technology call for the constant adjustment of knowledge and very often for the acquisition of new skills. Careful studies should facilitate the choice of technical areas in which training can be organized and also enable the content of the programmes to be determined.

3.2. Improvement of working conditions

At the same time economic and social progress has led to a number of changes in working conditions which will facilitate rehabilitation:

- the humanization of places of work und supervision of hygiene and safety measures;
- greater concern for the health, social problems, training and development requirements of employees;
- reduction in the number of hours worked each week, increase in the periods of rest and paid holidays;
- general introduction of compulsory insurance covering all risks.

All these measures make working life less demanding and should make it still easier for disabled persons to return to an active life.

These measures are, however, not all generally applied and there are still shortcomings. A great deal remains to be done. Certain seriously disabled persons who would be able to follow courses of occupational training leading to highly skilled jobs, cannot always be helped because they tire easily; the general introduction of part time openings would make their rehabilitation easier.

Technical and social progress leads to new problems. Motor vehicles which are indispensable for some disabled persons cannot reasonably be used by them under prevailing road traffic and parking conditions. The environment, pollution and tensions due to accelerated change are likely to be new barriers.

3.3. Inadequacy of job prospects

Occupational training for disabled persons is therefore facing the same problems as all vocational training.

What content should be chosen for courses when techniques become obsolete so quickly? A programme cannot be improvized; the progressive introduction to the subject taught, its suitability and practical value must be checked; a period of confirmation is essential.

What spheres of activity and skills should be chosen?

Agricultural, industrial and service activities are constantly changing. In the area which is of special concern to us the nature of disabilities has changed completely in twenty years: the sequels of tuberculosis and poliomyelitis have practically disappeared but the after-effects of serious injury, especially brain damage, and mental handicaps are becoming increasingly important. The training of educators and specialized personnel for whom the demand is growing all the time (doctors, psychologists, reeducators, social workers) must also take these changes into account.

What jobs can be filled?

What are the sources of information?

Forecasts and plans in every sphere soon become obsolete. The computer is a remarkable instrument but it only solves a problem on the basis of the data fed into it. In our particular area there seems to be a real need for a pragmatic approach - but we need the equipment and above all the manpower to do our job properly.

3.4. Orientation of training programmes

After analyzing and weighing up the basic principles and limits of occupational training programmes for the disabled, and after resolutely adopting the approach to be followed, a modern strategy for occupational training should set itself the following objectives:

- pinpointing and use of all the means necessary to develop individual aptitudes;
- provision of optimum general education;
- grouping the special branches of a given occupation together in a single unit so that adaptation to job requests will be a practical possibility: this structure also enables basic technological training to be given in common programmes and persons undergoing training can be led up to qualifications which match their level of knowledge and aptitudes;
- practical work must correspond as closely as possible to the realities of a job;
- courses of work in the chosen activity should be organized in order to test attainments, working rates and output.

A policy of this kind presupposes once again fairly large training establishments or coordination between different occupational training centres for disabled persons.

Above all we must work towards a general policy in which permanent training and medical and social measures are treated with the importance they merit.

Conclusions

Permanent training, retraining, adaptation and occupational advancement are a subject of concern to individuals, organizations and States all over the world. No doubt objectives are not agreed upon unanimously, but necessity is a law in itself.

For several decades now, that very necessity has given rise to the establishment in Europe of post-cure and occupational retraining centres, thanks to the energy of disabled persons themselves. In face of innumerable difficulties they have quietly demonstrated the validity of permanent training (even - and indeed especially in their case - during illness) and the need for occupational advancement.

Now that the rapid development of modern technology is making it necessary for occupational training establishments to be open to all workers, the disabled have a right to equal opportunities.

F. BOLL

Rehabilitation during recent years has progressively developed away from welfare assistance for the alleviation of need towards active assistance for self-help. There has been a growing recognition that by far the greater part of disabled persons can, irrespective of their cause of disablement, be integrated fully into industrial life, as long as certain essential conditions are met. Perhaps I might, at the outset, make one basic point about the extent to which all persons and, by comparison, all disabled persons are fit for work.

If, as would hardly ever be the case, it was possible in any one country to provide ideal conditions of general education and industrial training for all persons from early childhood onwards, then 94 per cent of them would be fully fit for work in at least one skilled occupation. Only about 6 per cent, for such reasons as physical debility or infirmity or mental retardation, etc., would not be fit for work or would only be suitable for labouring or similar jobs of inferior importance. Among disabled persons - including all causes and types of disablement, i.e. the physically, mentally and psychologically disabled alike - this proportion of 6 per cent unfit or not fully fit for work is increased by the effects of disablement to around 20 per cent.

To make the same point in rather more concrete terms - about 80 per cent of all disabled persons of working age could now make their full place in industry and society, regardless of the cause, severity or effects of their disablement, provided - and I shall be returning to this proviso again and again -that all the modern rehabilitation aids which have been shown by practical tests to be feasible are placed at their disposal.

Of all the disabled, in turn, only about 20 per cent might be in need of special care or a protective work environment offering some element of occupational therapy or continuous nursing. These claims are not based on simple optimism. Their substance can be verified by detailed investigations, sample surveys, practical experience and careful estimates. Equally, it can now be demonstrated that, given present-day forms and methods of industrial rehabilitation, at least 70-75 per cent of those 80 per cent who are capable of integration can be advanced to a higher occupational and social grade than they enjoyed in their previous job, or, in the absence of a previous job, than they would have enjoyed in a job of which they might have been capable before. It is only in the remaining 25-30 per cent of such cases where it has to be accepted that it will be possible "only" - and I put this "only" in inverted commas - for their previous social status to be more or less equalled.

Before I come to the appropriate forms and methods of present-day industrial training, I should like to outline some of the requirements which such training should be designed to meet.

Here the first things to be considered are the working conditions and job opportunities available to disabled persons at present or likely to become available to them in the future.

The industrial rehabilitation of disabled persons is being favoured increasingly by the rapidity with which the working and occupational environment of our advanced industrial society is being transformed. We are once again embarking on an era where ideas of employment which still seemed valid until a short time ago should properly be abandoned. The changes are that most of the standard occupations for which disabled persons have traditionally been fitted in the past will in future cease to be applicable. This is true, apart from minor differences, not only of young and adult disabled persons but also of the first and any subsequent stages of rehabilitation alike. Such traditional occupations as metal and other raw material working and fabricating, which still form the main planks of present programmes of industrial rehabilitation, should in future become relatively less important, representing as they frequently do for many disabled persons of limited mobility a risk which can nowadays be avoided. They are being replaced by a large number of similar occupations which, being unaffected by the constraints of a disabled person's physical performance, no longer constitute a mobility risk of this kind.

These cover, in the first place, the whole range of precision work occupations, from precision engineering and optical instruments to the manufacture of mechanical and electronic apparatus and small machine tools. Then there is the new job of operating numerically controlled machine tools, which even a heavily disabled person can perform in a sedentary position. The same applies to the broad spectrum of developing outlets in the field of quality control, which should be opened up to disabled persons, preferably long before they are taken over by workers of average industrial skill; for here a disabled worker who has been suitably trained can be at least as productive as, if not actually more productive than, his non-disabled counterpart. The large field of electronics - including general industrial applications, energy supply and telecommunications - already offers numerous opportunities for the disabled, while other branches are now being developed. Another important area is electronic data processing. May I quote just three examples of this.

Among quadriplegics, among the deaf and, these days, even among the blind, there are many who through this have been able to emerge from the shadows and, being at least as productive as the non-disabled, are now making a skilled worker's living. Take just the case of the training now being given in West Germany to blind computer programmers. Of course, a number of scientific and technical research and development projects have had to be undertaken first in order to provide the necessary equipment and mechanical appliances and to device suitable training courses for the blind. They have been completed successfully, and they have been well worth while. Now blind persons are being trained as skilled computer programmers within 18 months, while receiving at the same time such sound and forward-looking commercial training as their circumstances require. Most of them are without special previous experience. What they need is a specific talent and the necessary capacity for training. Many blind persons possess the capacity for logical thinking needed for this job or acquire it through their capacity for compensation.

The example quoted for blind and deaf persons and those with multiple disabilities in the field of data processing applies also to many other present-day occupations and is equally applicable to many other categories of disabled persons. It applies, for example, to epileptics, to persons suffering from brain injury or coronary thrombosis, to haemophiliacs, to many spastics, to cases of multiple sclerosis, to the psychologically handicapped, to those afflicted by muscular dystrophy, to hemiplegics and to many other kinds of disablement. The advanced kinds of job I have mentioned provide opportunities for disabled persons of practically every type and degree of disablement, wether their intelligence is modest, average, above-average or outstanding.

This is true not only of disabled men, but also as far as the permanent and complete rehabilitation of disabled women and girls is concerned. Thus our changing occupational and industrial environment is not merely providing a large proportion of disabled persons with better opportunities for employment than hitherto; for an equally large proportion of them it is also opening up the prospect of occupational rehabilitation for the first time.

These better or new employment opportunities are fostered in turn by universities of technical education, by trade and technical colleged, and - numerically the most important - by specialist training courses, culminating in the job adaptations and training facilities provided by industry or in the new conception of workshops for the disabled; for a mentally disabled person who has been successfully trained for employment in such up-to-date workshops in accordance with genuine criteria of social security, such as equal and fair pay or regular old-age pension schemes, can reasonably be said to have been effectively and completely rehabilitated.

Finally, the new working conditions and job opportunities, together with new methods of education, will relieve our educational activities of having, as in the past, to lag behind what is being done in other fields of industrial and academic education, and to rest content with whatever is left over. Given the present stage of development, we should be able not only to reverse this situation on all fronts in the foreseeable future, but also to anticipate other educational developments by several years and to maintain this lead indefinitely. This aim - which was little more than wishful thinking a few years ago, has already been realised in some areas, and will doubtless be accomplished in the remaining ones before long - is an essential objective which rehabilitation should set itself in the seventies.

Another aim, equally important and assisted by the same factors, is to help disabled persons as far as possible to better themselves both in their careers and socially. Those unable to do so, and hence dependent on the natural course of events or something rather less, should be only a tiny majority.

Attuned to our day and age, these targets set for the industrial rehabilitation of disabled persons are certainly no longer based on wishful thinking; they could soon, as is indeed the case to some extent in a number of countries already, come within th reach of the majority of the 80 per cent of disabled persons who are fit for work. For this, it seems to me, the following are the most important conditions required:

1. It is essential that disabled persons should receive advice which is both timely and sound. Dilettantes and semi-professionals, however keenly committed and socially minded,

should be avoided. The right course must be set from the very outset. This calls for the co-operation of several specialists in various disciplines. The role of the single, central adviser or all-rounder is, I suggest, a thing of the past, being all too liable to lead to superficiality in some areas, and thus to misjudgment, or at least failing to guarantee an optimum result. Hence the need for industrial rehabilitation to be handled by groups of advisers, consisting at least of one careers and employment adviser, one or more doctors, a diagnostic psychologist and an engineer acting in an advisory capacity.

2. In many cases, this group of advisers will only be able to pave the way for a disabled person's occupational rehabilitation in the proper manner if his skills and interests can be accuretaly assessed. Normally it should be possible for such an assessment to be based on a detailed psychological aptitude test which relates skills to possible performance and indicates preferences.

3. In future, a manufacturing company will no longer be able to provide disabled persons with adequate and up-to-date training facilities. Hence the greater part of the industrial training, re-training and extension courses and adaptations for disabled persons will have to be provided at a higher than company level, if not outside companies altogether. Industrial rehabilitation facilities provided outside companies will be mostly mixed, having to cater for all types of disablement or for a majority of them at one and the same time. Specific facilities for a particular category of disabled person will be necessary and desirable only in a few exceptional cases. All facilities will nevertheless have to differentiate between those for juveniles and those for adults. A combination of the two, given their different capabilities, is no longer practicable. Industrial rehabilitation centres for adults will look after disabled persons of 18 years of age and over, and employ in most cases

quite different methods of training from those suitable for juveniles.

Industrial training courses for disabled persons should be reviewed by specialist committees at least twice a year and kept continuously up to date. Similarly, their instructors - who now, unlike previously, should preferably have graduated at a technical college - ought to keep themselves regularly abreast of the times by a three-week practical course in a company once a year and by a programme of three-day refresher courses once a quarter. Failing this, the benefits obtained by disabled persons from industrial training at a rehabilitation centre will rapidly become open to question.

4. a) - Another major prerequisite is the application of new teaching and learning methods and materials which are strictly tailored to the disabled persons individual circumstances. Industrial training of disabled persons should adopt, as far as possible, the technique of group instruction combining the most diverse types of disablement. The optimum group size is about 15 for juveniles and 25 for adults.

b) - An essential element of industrial training of disabled persons is the teaching of new skills. To begin with, having regard to many disabled person's limited capacity for abstraction, this should wherever possible be "visual". Equally important in all cases, and particularly in the case of disabled adults, are the various "forms of co-operative learning", including above all seminar and group work, discussions and debates,tutorials and team teaching, all of which encourage the disabled person's active participation in the training procedure.

The traditional function of training, which is to communicate information, is thus replaced by a recognition of associations, structures and relationships, as well by an acquired ability to transfer what has been thus recognised.

Disabled trainees must learn at an early stage to pass from imitative to productive thinking. The teacher-pupil or foreman-apprentice relationship which, if only in a figurative sense, is still widespread should also be superseded by one of genuine collaboration, the style and atmosphere of which are determined by the idea of partnership and equality between the disabled student and his instructor.

The same importance attaches to automated teaching techniques. Here the value of learning programmes as a prime tool for getting the best out of a disabled person's industrial training - wether in a preparatory or auxiliary role or as a labour-saving substitute - has already been well established. Beyond this, their practical use and permanent availability from a programmed reference library for the purpose of homework will be equally indispensable. Apart from private study, they lend themselves particularly to coaching - for making good "weaknesses" or reinforcing distinct strengths of ability in individual cases. This also takes care of the need for selective courses, which are no less important for the individual than are combined courses for the entire class.

Doubtless the most portentous and promising of all the available industrial training techniques for disabled persons, however, is computer-aided instruction, whereby a computer fitted with special equipment and modelled on learning programmes can nowadays be used as a teaching and learning machine of supreme adaptability.

This requires a data processing unit with separate input and output terminals for the students, a programme control operating system for process organisation, and a programming language for industrial training programmes. Computer-aided instruction is suitable not only for industrial training and re-training of disabled persons, but also for advanced courses and job adaptation. By means of teleprocessing from a central data bank serving a number of connected industrial rehabilitation centres in widely separated places at one and the same time, it is also possible to produce a variety of programmes for individual students or entire classes simultaneously.

Another learning technique for the industrial training of disabled persons which has already been successfully tested in prototype is educational tele-viewing at home. This calls for a mobile central studio connected to recording and transmitting rooms for live or "canned" broadcasts, and operated by a small team of highly trained specialists supplying a centre's entire industrial training curriculum. The installation of such a system in industrial rehabilitation centres - for which an economic model is now being developed, for example, in West Germany - will certainly become a practical proposition in the foreseeable future, when hardly any of these centres will be of less than a certain minimum size.

Audio-visual teaching aids like sound films and 8-mm documentary films are additional tools which no up-to-date industrial rehabilitation centre for disabled persons can nowadays do without.

The same is true of language laboratories, the use of which has already been extended far beyond the teaching of foreign languages, and which can also be of valuable service to industrial training in "verbal subjects" of other kinds.

Equally essential for the industrial training of disabled persons in the future is the study centre, where all ready-made teaching aids and materials needed for private study in industrial training are available.

So much for new - and already well-tried - methods and forms of automated teaching designed for the adjustment, training, re-training and advanced instruction of disabled persons to the best possible effect. Some are already being applied within one large industrial rehabilitation centre, while the practical application of others is imminent.

c) - But the industrial rehabilitation of disabled persons does not only depend on proper methods and systems for communicating information; it also requires the communication of new or enlarged industrial skills. Far from the time needed for learning such skills being longer for most disabled than for non-disabled persons, as superficial observers still tend to think, it is often a great deal shorter. This time saving is perfectly possible and natural with regard not merely to job adjustment and further training but also to initial training and re-training. It reflects partly the disabled person's superior motivation, but results above all from the application of new skill-learning methods and techniques, whose benefits are already being realised in practive by a number of large industrial rehabilitation centres.

Anyhow, there is no place these days in the industrial training of disabled persons for the monotonous skill-teaching exercises of the conventional kind, which are irritating and frequently ineffective, if they do not actually result in training being broken off altogether.

5. If industrial rehabilitation is to be conducted efficiently, perhaps the most urgent need is that at all stages - during settling in, in initial and advanced training, and during re-training - instructors employing the latest techniques, therapists of every kind, qualified social and welfare workers should all work together as a team. For many disabled persons, particularly for the severely handicapped and still largely helpless cases I mentioned earlier, the services of such auxiliaries are absolutely essential if their training for and integration into industry are to be successful. This once again demonstrates the limited scope for adequate industrial rehabilitation

within one factory, and underlines the need for outside facilities. Throughout a course of industrial training the collaboration of instructors, careers teachers, doctors, psychologists, social therapists, sociologists, welfare workers and paramedical experts is imperative. In other words, many disabled persons will only be completely rehabilitated in accordance with modern objectives if diverse auxiliary services form an integral part of their training.

These are a few, by no means all, of the conditions which modern standards of industrial rehabilitation must satisfy. They have undergone thorough testing, and several centres are already applying many of them with success. For practical purposes, such application should not remain the exception but become the rule.

Thus, and only thus, will it be possible for any persisting prejudices against the employment of disabled persons in general, and especially against certain particular types of disablement, against the elderly disabled and against disabled women, to be broken down completely.

In conclusion, I should like to stress once again that all the indicated methods, forms and procedures for the up-to-date industrial training and rehabilitation of disabled persons, with particular reference to the seriously disabled, are not utopian or intractable ideals but realistic working models, which have already been tested and introduced in a number of rehabilitation centres. They are also perfectly justifiable and feasible in terms of economy, efficiency and public expenditure. This straightaway takes the wind out of the sails of one criticism which forward-looking techniques of industrial training have to face not infrequently. In the final analysis, the use of a computer in rehabilitation centres, to take a simple example, far from being an extravagance, more than pays for itself within a short space of time. Ultimately, the technical and scientific foundation without which occupational rehabilitation will be lost in future, far from being an additional cost, will prove more economic than the prodigality and improvisation, frequently bordering on dilettantism, of earlier days. Among other major social needs of our age, modern industrial rehabilitation is in the end the one whose financial cost in relation to its high fiscal and financial benefits is the lowest. I am always extremely cautious and reluctant to mention this aspect of the matter. But at the time when many on whom we depend are inclined to allow their thinking and feeling to be largely governed by the slide-rule, it can no longer be altogether overlooked. This should of course not detract from the fact that the overriding object of industrial rehabilitation is man, whose position in the centre of all our thoughts and efforts must and will always remain sacrosanct.

DISCUSSION

O. DEMOL

Most of the papers on the preparation of the disabled for work were chiefly concerned with traumatological re-adaptation. This is based on kinesitherapy and ergotherapy as a preparation for retraining for work, and on vocational rehabilitation. As has been stressed, of course, psychotherapy is involved at all these stages.

There are however a series of disabilities connected with internal medicine and which have certain peculiarities. Let us take by way of example persons suffering from neurological disability as a consequence of impairment of the central nervous system, such as hemiplegics.

a) At motor level, the problems are extremely complex; in addition to the motor deficiency proper there are manifestations of hypertonus, synkinesis and sensory disorders which have repercussions on motivity. The treatment of such patients involves a profound knowledge of neurological laws, and should be strictly differentiated.

b) The central neurological attack is often accompanied by disorders of the corporal system, praxic and gnosic disorders, psychometric deficiencies, behavioural disorders, and speech disorders such as the various kinds of aphasia. Neuropsychological and neurolinguistic evaluations must be added to the kinesitherapeutic and ergotherapeutic evaluations and treatments. Here the role of the neurologist, the psychologist, the neurolinguist and the orthophonist (logopaedist) is preponderant.

c) The causal sickness may be evolutive and be accompanied by relapses and complications in other spheres.

d) The etiology is not always established when the disabled person is sent to the rehabilitation centre. Hemiplegia is often regarded as being of vascular origin, whereas an electroencephalographic, echoencephalographic, arteriographic or scintigraphic investigation sometimes results in the discover of a subdural haematome or a tumour amenable to surgery.

For these various reasons, functional re-education must start at an early stage within the precincts of a general or neurological hospital possessing satisfactory diagnostic resources.

Under these conditions the functional re-education of such patients produces good results.

At vocational level, hoewever, a lot remains to be done. A paralysis in a longitudinal direction with loss of the accurate motivity of one hand is, in many respects, more disabling than a paralysis in the transverse direction, to say nothing of the intellectual disorders and those of the symbolic and phasic functions.

Then again, such patients are, for neurological (in the case of a left hemiplegia) or psychological reasons, often anosognosic. Most hemiplegics in fact refuse to accept the sequelae of their disability and take refuge in the illusion of a restoration ad integrum before wishing to start work again.

The problem becomes dramatic in the case of young patients of between 20 and 30 years of age whose central nervous system has been injured as the result of a cranial traumatism, disorders of cardiac rythm, embolic phenomena, precocious arteriosclerosis or a tumour operation. More often than not they vegetate in idleness.

Finally, this example chosen from amongst many (and the same could have been said of rheumatics and pulmonary or cardiac patients) shows that where the medically disabled are concerned, rehabilitation is a matter for specialisation.

As far as medical students are concerned, the training of doctors should consist essentially of general information on rehabilitation problems for a few hours during the course, and a course by selection in a rehabilitation centre. On the other hand, the teaching of specialised rehabilitation should be included in the various post-graduate courses.

L. VACCARI

Our difficult task of resettling disabled persons is the more necessary because of the increasing magnitude and complexity of the factors to be coordinated in connection with their particular condition, which does not always succeed in overcoming that sense of discouragement which stems from their physical inferiority complex. But once society has succeeded in developing their personality, its duty is to integrate them like normal people.

Consequently, well-considered legislation, which still needs to be drafted on a wider and more satisfactory basis, could make of the disabled, in the progress of production, a new victory of man over the physical world.

I am, however, convinced by my own experience of many years that it is not enough for a disabled person to know how to do a single job: he must learn various kinds of work in keeping with his aptitudes so as to improve his chances of employment and thereby to give him increased confidence in his newly-found working energies and abilities.

This would make much easier the integration of the disabled into society on a basis of equality.

It is not other people's pity that the disabled want, but the chance to become normal workers conscious both of their rights and duties: for employment alone can give them the independent life they seek.

A. MONTICELLI

The vocational re-training of industrial cripples and disabled persons whose disability prevents them from returning to the work they were performing at the time of the accident is one of the basic tasks of the Associazione Nazionale Mutilati ed Invalidi del Lavoro Italiana (Italian National Association for Industrial Cripples and Disabled Persons).

In some eight years, over a thousand industrial disabled have been vocationally retrained and have subsequently found employment as radio and television mechanics, switchboard fitters, lift fitters, lift service mechanics, machine draughtsmen, milling machine operators, turners, welders.

On completion of the retraining courses, which last about a year, the industrial disabled take proper examinations before a board appointed by the Italian Ministry of Labour and Social Security and receive a diploma in respect of their vocational qualification.

Time does not allow me to describe all the difficulties and obstacles which had to be overcome to obtain positive results from this retraining process.

However, we may briefly say that:

1) if appreciable results are to be achieved, vocational retraining must be aimed at a group of not more than twenty disabled persons of similar age and similar aptitudes for work;
2) the disabled who are to be given vocational retraining should make a start at the Vocational Retraining Centres immediately after their clinical cure, so as to prevent the emergence of that renunciatory mentality which represents one of the greatest obstacles to resettlement in a job;
3) vocational training methods should wherever possible make use of unmodified equipment, so that the disabled may learn to use the same equipment that they will encounter at work;
4) the programming of the retraining courses should take account of current labour shortages, so as to enable a disabled person to be quickly resettled in that category of work in which he has been retrained; obviously, when considering shortages of labour, account should be taken if possible of

labour shortages in the region in which the disabled person resides, so as to preclude the necessity of moving to another region, even though within the same country.

There is, however, no concealing the fact that a reasonable standard of education forms the basis for obtaining a vocational qualification, and the new programme being carried out at the centres operated by the Associazione Nazionale Mutilati ed Invalidi del Lavoro Italiana provide for a substantial increase in the teaching of subjects with work, such as mathematics, geometry, physics, drawing and general educational subjects.

Technical progress now calls for highly qualified workers, and proper studies are necessary in order to obtain such qualifications.

The Associazione Mutilati ed Invalidi del Lavoro Italiana has recently introduced retraining courses of a commercial type for young, keen and better-educated industrial disabled persons. At the end of these courses these disabled persons all found work as commercial correspondents and shorthand typists.

The problem of the vocational retraining of the disabled must, therefore, always be viewed in terms of positive reintegration in the working world, even if the means of achieving this objective may differ in the various countries having regard to the requirements and needs of labour, of technical and technological development, etc.

Nevertheless, suitable changes in the law must always be accompanied by continuous and persistent persuasion of the disabled person and his employers:

(i) the disabled person should be made to see that society still needs him;

(ii) employers should be made aware of and made to recognise the new-found truth that retrained disabled persons can be made use of as able workers provided they are employed on work compatible with their aptitudes.

S. FOUCHE

It is desirable that an assembly of competent and influential persons should be the occasion for practical decisions which facilitate the work of one and all, and solve at least some of the major problems.

What would we like to see, therefore, by way of help in the rehabilitation of the disabled? An exchange, an almost complete pooling as a result of which all would benefit from the discovery of each.

Exchange of people:

Our doctors, physiotherapists, occupational therapists, nurses, orthophonists, psychologists, teachers, technical instructors and their superiors would find it a great advantage to go and see for themselves on the spot what is being done abroad, to compare their methods, and to widen their horizons.

Their pay and social benefits would have to continue to be provided by their original employers, and they would have to be replaced by a practitioner of a similar discipline. This assumes an "exchange scholarship" and the necessary linguistic preparation.

Additional costs - such as travelling expenses - could be paid by the Commission of the European Communities.

Exchange of documentation: systematic

Each country to send periodicals, publications, articles, reports, etc. to all the others, so as to give an account of setbacks experiences and to save others the need of repeating them at first hand, and of the successes and the conditions surrounding them so as to provide guidance for projects and to speed their advancement.

By that I mean the intercommunication of new treatments for spastics just as much as architectural plans and basic training which may be suggested for the disabled. We are interested in all relevant information, but perhaps a central body would be necessary to draw our attention to it, summarise it in our own language, and give us details of the source and the appropriate person to whom we should apply.

Exchange of equipment: without customs or Exchange Control barriers.

We could - especially in the case of fitting, prostheses, adapted vehicles, gadgets and physiotherapeutic material - draw our supplies from whichever country makes them better than we do, at the normal price, and be reimbursed by our Social Security or Social Assistance organisations after the model had been quickly approved.

This would result in the rationalisation of production, thus eliminating much research work and reducing prices and production times. The provision of patented inventions free of charge should also be considered.

The Ligue pour l'Adaptation du Diminué Physique au Travail has, for instance, just entered into an agreement to supply the Spanish Railways free of charge, with all the patented drawings of its physiotherapeutic equipment, on condition that the Ligue should be informed of any improvements made to the models, that it should similarly be supplied with the drawings of Spanish inventions, and that both parties undertake not to compete with one another in their own countries.

When are we going to achieve this international solidarity? It was at the Congress of the International Society for the Welfare of Cripples in Budapest in 1936 that I called in the same terms for such exchanges on behalf of the disabled. Hitler's Germany opposed the idea. The Germany of today would be a fervent supporter of it.

May we hope that it will not take another 35 years before the idea becomes a reality?

D. KOKE

Mr. BOLL has painted an ideal picture of rehabilitation, to which I add my support. After all, what is impossible today must be made possible tomorrow and become the reality of the day after. The success of the rehabilitation measures depends, however, on four factors:

I. The correct choice of the candidate for rehabilitation, at the right time.

The general practitioner must break down the obstacles to rehabilitation and become a decisive factor in the matter. The general practitioner, the works doctor, the hospital doctor and the Health Insurance doctor are often in a position, in their capacity as doctors, to recognise the patient's need of rehabilitation.

In the case of severely disabled persons, the hospital bed is the point at which contact must commence.

Rehabilitation must begin in the hospital bed, at the instigation of the hospital doctor. Rehabilitation must fit into the picture by an imperceptible transition. A lethargic state of "hibernation" must not be allowed to develop. That is why preparations for the change-over must commence during the period of unfitness for work.

If this is to be accomplished we need chairs of rehabilitation, lectures in universities, arrangements for students to act as assistants in rehabilitation establishments, and comprehensive courses of instruction for the attendant doctors.

II. The success of rehabilitation depends on the proper amalgamation of all scientifically-recognised and practically-proven methods whilst medicinal and vocational rehabilitation processes are being carried out.

This necessitates research, which, in the field of rehabilitation, needs to be intensified.

III. Agreement on terminology is also necessary in the European Community. This is a job for the Organising Committee.

IV. Continued systematic care of the persons undergoing rehabilitation and those who are "conditionally fit" is necessary not only after they have been discharged from medical rehabilitation, but also after vocational rehabilitation has been concluded.

Care of the family is also part of this, as are psychological and medical guidance and assistance in connection with our housing.

In an affluent society a life compatible with human dignity requires not only permanent, but essentially also participation in public cultural life. Rehabilitated persons should have no need of pity; what they need is active assistance and social comprehension.

Social comprehension also compels us to persuade architects to ensure that public works and other building schemes are planned and executed with the disabled in mind.

We are just at the beginning of a great task whose problems, unreal as they often may be today, must become tomorrow's reality.

K.A. JOCHHEIM

The gap between the tasks and aims of vocational rehabilitation as formulated and the realities of life necessitates further far-reaching political commitment in the various countries of the Community. If it is to succeed, a political task of this kind must be based on sound research results. Today we lack sufficient reliable data on the problems of the aptitude, the capacity and the motivation of the disabled. I therefore beg the European Communities to create, by promoting research into the problems mentioned, the preconditions for the subsequent political tasks.

PLACEMENT

LEGISLATION OF THE MEMBER-COUNTRIES OF THE EUROPEAN COMMUNITIES

Chairman: Dr. MEISEL
Bundesanstalt für Arbeitsmittlung und
Arbeitslosenversicherung
Deutschland

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REPORTS

M. MARON

I. Legal aspects of the employment of disabled persons in the member countries of the European Community

Analysis of the legislations pertaining to the disabled in the European Community reveals a constant progression in the approach of society.

In every country, including non-Community countries, the attitude of society to the disabled is characterised by the following aspects:

a) Rejection of the invalid

The invalid is regarded as useless, harmful and often even possessed by evil spirits.

Plato, for example, advocated the slaying of deformed children, whilst his disciple Aristotle was a protagonist of the infanticide of malformed children.

It was the custom of the Spartans to abandon malformed children and allow them to die by exposure to nature or marauding animals.

Did not Samuel, the greatest of the twelve judges of the Israelites, bar the blind and the lame from entering the Temples lest they defile the altars?

b) Pity and charity

The attitude of rejection of the invalid weakened during the period of the Hebrew "Kings", during which the influence of the "prophets" brought about a transformation of the fundamental rights of man, thus creating a climate favourable to Christianity for the development and evolution of different social attitudes towards the disabled.

Under this climate of opinion, certain religious authorities granted the disabled the privilege of obtaining alms in the parishes.

This consecration of the right to charity marked, and, it must be admitted, still marks, the attitude of society towards the disabled.

Is it tolerable today that this idea of charity should still be valid?

The answer is an emphatic no. The charitable act towards the disabled person allows the donor to assuage his conscience and feel that he has done his duty, whilst at the same time giving him a feeling of superiority over the recipient; the latter, on the other hand, thereby has his inferior status confirmed.

Charity thus strengthens the notion of the segregation of the strong from the weak, and in the last analysis is prejudicial to the integration of the disabled into the community.

c) The right to assistance

From the 16th century, this idea of charity resulted in most of the countries of the Community in the opening of "hospices for invalids" and "charitable organisations" to give succour to the most wretched of the invalids.

It was not until the second half of the 19th century that public assistance laws were passed in each country, by which the State assumed responsibility for assuring (after a fashion) the subsistence of indigent citizens, and in particular, of invalids.

Thus, the idea of charity gradually gave way to a civil entitlement to assistance.

d) Entitlement to compensation

At the same time, probably thanks to the Napoleonic Code, there arose in the various countries the concept of entitlement to compensation for damage sustained as a result of a deliberate or even involuntary act by a third party.

1) Accidents at work

Perhaps this idea of compensation lies at the root of the legislations in the various countries relating in particular to persons suffering accidents at work.

Legislation providing for compensation and indemnification for accidents at work developed in each of the member countries of the Community around the end of the 19th and the beginning of the 20th century.

In general, these different legislations provide not only for compensation for the damage suffered but also, although still to a very limited extent, for the resumption by the victims of accidents at work of their place in the economy.

Gradually, with the development of medical and vocational rehabilitation techniques and of attitudes towards the disabled, these legislations have been adapted to fit the idea of rehabilitation and resettlement more closely.

For instance, the law of 30 April 1963 on accident insurance in the Federal Republic of Germany affirms the principle contained in the law of 1884 that restoration of the capacity to earn must take precedence over the granting of a pension.

Similarly:

a) The Italian legislation of 1898 introduces the concept of rehabilitation and vocational re-education of the victims of accidents at work;

b) The French laws of 9 April 1898 stipulate that the victims of accidents at work shall benefit from re-education measures;

c) The legislation of 5 April 1902 of the Grand-Duchy of Luxembourg contains provisions reserving certain jobs to the victims of accidents at work;

d) The law of 1921 on accidents at work in the Netherlands provides for rehabilitation;

e) The Belgian legislation of 1903, as modified, in particular, by the Orders of 22 February 1936 and 14 April 1938, organises medical treatment and functional rehabilitation of the victims of accidents at work.

2) War victims

The idea of entitlement to compensation, combined, of course, with that of national gratitude, was furthered by the First World War (1914-1918), forming the basis for a series of enactments, sometimes providing for more or less clear-cut rehabilitation measures. This applies to the following laws:

Law of 12 May 1920 (German Reich)
Law of 11 October 1919 (Belgium)
Law of 31 March 1919 (France)
Laws of 20 March 1917 and 21 August 1921 (Italy)
Law of 26 February 1945 (Grand Duchy of Luxembourg)
Law of 1945 (Netherlands)

All these laws were revised and remodelled between the wars, but in any case paved the way for revision of the relevant legislation in each country after the Second World

War (1939-1945).

These new provisions consolidate the idea of compensation, but also take account of the development of retraining methods and the possibility of re-integrating military and civilian victims of the war into economic life.

These new enactments:

Law of 21 December 1951 (Federal Republic of Germany)

Laws of 28 March 1951 and 28 June 1956 (Belgium)

Decree of 20 May 1955 (France)

Law of 10 August 1950 (Italy)

Order of 20 February 1945 (Grand Duchy of Luxembourg)

Law of 1945 (Netherlands)

generally institute particular rights in favour of war victims: the right to medical care, to rehabilitation and to employment under certain conditions.

This evolution of the idea of compensation let naturally to the notion of the social right.

e) The social right

During or immediately after the Second World War, there arose in each member country of the European Community the notion of a social right to medical treatment , medical and vocational rehabilitation and job placement.

This new conception of social legislation originated in the generalisation of the rule of "social security" instituted in the different countries by:

The laws of 23 February and 21 May 1957 (Federal Republic of Germany)

the law of 28 December 1944 (Belgium)

the decree of 29 December 1945 (France)

the law of 24 April 1954 (Grand Duchy of Luxembourg)

the law of 4 April 1952 (Italy)

the law of 18 February 1966 (Netherlands)

However, these legislations originally applied only to wage-earning workers and their families, but are gradually coming to encompass the other sections of the population, guaranteeing them the right to medical care, possibly including entitlement to medical or sometimes vocational rehabilitation services.

f) The right to rehabilitation and work

As stated above, the trend of legislation in the different countries is not only to provide compensation for damage suffered but also, although in some cases hesitantly, to establish the concept of functional and vocational rehabilitation and to encourage the resumption of work.

However, as a rule, the legislations provide that these benefits are the entitlement only of specific classes of beneficiaries.

The step that remains to be taken to confirm the social evolution in the different countries is to establish in the legislative provisions the "right to rehabilitation and social resettlement" of all disabled persons, regardless of their social status and the origin of their disablement.

Some national legislations have already established this principle for part or all of their rehabilitation or employment services, for example:

Germany:	the law of 25 June 1969 on the furtherance of employment
Belgium:	the law of 16 April 1963 on the social resettlement of the disabled
France:	the law of 23 November 1957 on the resettlement of disabled workers
Italy:	draft law to be promulgated by 31 December 1971
Grand Duchy of Luxembourg:	the law of 28 April 1959
Netherlands:	the law of 14 December 1967.

It would appear desirable for the six countries of the

Community to study and analyse the different benefits granted to all classes of disabled persons, both congenital and others, at all stages of preparation or rehabilitation and employment, in order:

1) to guarantee all cititzens the right to rehabilitation and integration in the economy
2) to enable all citizens of the Community to enjoy the same rehabilitation services, regardless of the Community country in which they live.

This is the objective which should be the guiding principle of this symposium on the rehabilitation of the disabled, organised by the Commission of the European Communities.

II. Study of the measures taken by the governments of the countries of the Community to promote:

Occupational preparation
Employment of the disabled
Placement of the disabled

A. - Occupational preparation

Germany

Three laws (dated 23 February and 21 May 1957) contain provisions to reorganise the occupational rehabilitation and re-education of the physically handicapped and make the bodies responsible for manual workers' and clerical workers' pension insurance and the miners' scheme responsible for the execution of the relevant measures.

The application of these measures is the responsibility of the Länder Insurance Institutes, the Federal Clerical Workers' Insurance Institue and the Mine Staffs Pension Insurance Institutes.

The law on the furtherance of employment of 25 June 1969 charges the Federal Office of Labour of the Ministry of Labour and Social Affairs with the co-ordination of rehabilitation measures through the use of its specialized services and the network of regional offices giving direct access to the labour market.

The Office is to provide both individual and collective services under these arrangements.

Belgium

Occupational preparation, under the Ordinance-Law of 28 December 1944, for persons covered by social insurance or in certain cases their entitled dependants, falls

a) under the sickness/disability insurance scheme for persons with 66% or more disability, or
b) the unemployment insurance scheme for persons with less than 66% disability.

However, the law of 16 April 1963 guarantees all disabled persons, irrespective of the nature or origin of their disablement, and irrecpective of their status, the benefit of vocational training or rehabilitation. This provision thus gives all Belgian citizens, and in certain cases foreigners resident in Belgium, the right to vocational training and rehabilitation, based where applicable on the 1944 social insurance legislation.

The law of 16 April 1963 is intended to grant all disabled persons with 30% physical or 20% mental incapacity the benefit of medical and vocational rehabilitation, job placement and social assistance, to enable them to resume their place in economic life.

France

By virtue of the decree of 29 December 1945 containing Book III of the Social Security Code, persons participating in social insurance schemes and their entitled dependants are entitled to the services of vocational rehabilitation and re-education.

Furthermore, since the Ordinance of 21 August 1967, the social security scheme includes persons voluntarily insured, who are also entitled to occupational re-education and rehabilitation.

It should, however, be pointed out that under the law of 23 November 1957 on the resettlement of disabled workers, any person whose chances of obtaining or retaining a job are actually reduced in consequence of insufficiency or reduction of his physical or mental faculties is entitled to vocational rehabilitation measures.

In addition, under this law, all establishments or groups of establishments belonging to the same sector of activity and having more than 5.000 workers are required to look after the retraining for work and vocational re-education of sick or injured employees of the establishment or group of establishments.

Italy

The laws of 5 October 1962 and 6 August 1966 stipulate specific measures for civilian invalids and physically disabled persons, without distinguishing between the different types of disablement causing their invalidism.

These laws provide for the institution of vocational training courses open to invalids selected by a provincial commission.

Civilian invalids and disabled persons who are unable to attend normal training courses because of their physical disability may be placed by the Ministry of Labour and Social Welfare in specially designed courses at the vocational re-education centres of the National Institute of Insurance against Accidents at Work, the National Relief and Assistance Organisation for War Invalids, and the Free National Association of Civilian Disabled Persons and Invalids.

Grand-Duchy of Luxembourg

Under the law of 28 April 1959, disabled workers may ply for the benefit of vocational re-education.

If this vocational re-education is considered neces-ry by the Office de Placement et de Rééducation Profes-onnelle des Travailleurs Handicapés, the cost is met:

1) by the State for war invalids;
2) by the accident insurance scheme for victims of accidents at work.

The employer collaborates in vocational re-education making his equipment, installations and normal tooling ilable to those concerned.

Netherlands

The measures to be taken to improve working capacity left to the discretion of the trade organisations, ch are charged with the application of the law of 18 ruary 1966 relating to insurance against incapacity to k.

However, this law of 18 February 1966 set up a "joint ical service" in respect of services not covered by sick-s insurance (services in kind).

The joint medical service co-operates with the medical urance funds as regards medical treatment. It takes necessary action in connection with vocational or social abilitation.

B. - Employment

a) Compulsory or priority employment

Germany

On 3 July 1961, the Parliament of the Federal Republic ermany passed a law on the employment of invalids, co-ing the previous legislation on the subject. This law nes the "severely disabled" as persons of German onality whose earning capacity has been permanently re-d by at least 50% in consequence

a) of the war;
b) of an accident at work or occupational disease;
c) an injury following persecution by the National Socialist regime, on political, racial or religious grounds; or
d) a combination of these factors.

The law also applies to blind persons of German nationality, independently of the above provisions, if they are permanently resident in the Federal Republic or the western sector of Berlin. Persons who are not of German nationality but live in the Federal Republic or the western sector of Berlin, whose earning capacity has been reduced by at least 50% due to one or more of the causes set out above, may also benefit from this law if they are entitled to invalid benefits.

By assimilation, the benefits of this law are also an entitlement of persons whose earning capacity has been permanently reduced by at least 30%, by virtue of one or more of the above causes (a), (b) and (c), and who are unable to find work.

The law also covers other persons whose earning capaccity has been permanently reduced by at least 50%, but who cannot claim classification as "severely disabled persons" and who are unable to find work, provided that their placement does not prejudice that of "severely disabled persons". The benefits in this case are confined to specific undertakings and a time limit may be imposed.

Employers employing more than nine persons (Federal and Land administrations, local administrations and non-profit-making associations and foundations) are required to employ a quota of invalids equal to 10% of their total staffs. In the case of public und private establishments, any employer employing more than fifteen persons is required to engage a quota of invalids equal to 6% of his total staff, and in any case at least one invalid.

These percentages may be increased to a maximum of 12% and 10% respectively, or reduced to a minimum of 4%, by decision of the Federal government. Any Land government employing a quota exceeding the maximum of 12% may lay down a similar quota for local administrations and for the non-profit-making associations and foundations falling within its jurisdiction. Regional employment offices may in certain specific cases impose special maxima of 24% and 20% respectively, or reduce the quota to a minimum of 2%. Under certain circumstances, employers with a staff of five or six may be required to employ at least one invalid.

Arrangements are to be made for these quotas to include a sufficient proportion of war- and other blind, persons entitled to special aid grants, persons with brain injuries, tuberculosis patients and persons whose earning capacity has been reduced by at least 80%.

The Federal Office may in certain cases count each post occupied by an invalid whose placement meets with particular difficulties as being equivalent to two reserved posts.

An invalid may be counted as one unit of the quota if employed for at least twenty-four hours per week. Certain persons are not counted in calculating the strength of the labour force for the purpose of fixing the quota (e.g. apprentices under contract, persons undergoing vocational re-education for a minimum of six months, where the cost is met by public funds).

As to the fixing of the number of posts, establishments belonging to a single employer will be considered separately for the purpose of determining the quota. At the request of the employer, the establishments may be grouped together for the purpose of fixing the number of posts.

Work at home by persons employed mainly by a single employer is regarded as equivalent to "jobs" or "working posts". The obligation to employ invalids falls exclusively to this employer. For the purpose of calculating the number of posts, the basis is not the number of workers, but the quantity of work distributed; this will correspond to the quantity of work performed by a worker in an establishment engaged on identical or comparable work.

Employers may discharge their obligations under the law by organising centres or accomodation for the invalids or by making it possible for another employer to employ a larger number than his assigned quota.

Provided that the necessary professional standard of competence is reached, public administrations must give preference, in the filling of women's posts, to widows whose husbands died from injuries received on active service or as a civilian for reasons directly attributable to the war, widows of persons registered as missing on active service and of prisoners of war, and the wives of invalids who are incapable of working. The employment of a widow or wife satisfying these conditions may be counted as half a unit in an employer's quota, provided that this employment does not prejudice the prospects of employment of an invalid and that the widow or wife is unable to find other employment. In this case, the widow or wife must receive a contract providing for a period of notice of not less than eight weeks.

The invalid cannot be dismissed without permission from the main assistance office, and the period of notice is not less than four weeks. The application for dismissal may be approved in the case of a firm which is closing down permanently or reducing its staff, provided that it continues to discharge its quota obligations after the reduction in staff is completed; if another suitable job can be found for the invalid, or if the invalid is over 65 years of age and evidence is furnished that he has means of subsistence. These provisions do not apply in certain cases (e.g. immediate dismissal for a reason unconnected with the physical disability of the person concerned; temporary stoppage due to strike or lock-out).

Private employers who do not fulfil their obligations as to invalid quotas are liable to a penalty of 50 DM per month for each quota post not filled. This fine may be reduced or cancelled in the event of exceptional difficulties for the employer, who may be exempted from it if, in spite of his efforts, he is able to discharge the obligation to employ invalids and the employment office has been unable to supply any.

The penalty may be reduced where the employer places orders with a firm having a sheltered employment section, half of whose staff are invalids. Revenue from these penalties may be used only for the purposes of vocational re-education of invalids or for the benefit of the widows and wives of invalids, the recovery and conservation of the working abilities of invalids, or assistance to invalids and the surviving dependants of war victims.

Private employers who have failed to discharge their obligations under the terms of the law may be required, to bring their quota up to strength, to engage an invalid designated by the local employment office. Such designation will be equivalent to a contract of labour between the employer and the invalid.

Employers subject to quota must notify the competent employment office of the number of staff employed, the number of invalids employed, and all conditions, etc., relevant to the employment of invalids. They must also keep a list of their invalids. All employers must occupy invalids in such a manner that they are able as far as possible to make full use of and to continue to develop their abilities and knowledge. Private employers must permit effective inspection as necessary for the protection of the interests of the invalids, but industrial secrets must be duly safeguarded.

Belgium

Co-ordination of employment policy for the disabled is provided by the Fonds National de Reclassement Social des Handicapés (F.N.R.S.H.).

a) Placement in the private sector

1) Engagement of disabled persons

Under Article 22 of the law of 16 April 1963 on the social resettlement of disabled persons, the Office National de l'Emploi is responsible for the placement of disabled persons registered with the Fonds National de Reclassement Social des Handicapés who have, where applicable, completed their training, rehabilitation or vocational re-education and are fit to work in private firms.

For this purpose, the Fonds National de Reclassement Social des Handicapés requires disabled persons who are fit to do a job to register as seeking work.

2) Compulsory employment

Article 21 (1) (1) of the law of 16 April 1963 on the social resettlement of disabled persons stipulates the compulsory employment of a specific number of disabled persons in industrial and commercial firms and on farms with a staff of at least twenty. The law provides for joint commissions of employers' and workers' representatives to give an opinion as to the percentage of disabled persons required to be employed by these firms and farms.

The number of disabled persons to be employed in each sector is to be fixed by royal order. However, these provisions have not yet been implemented.

3) Encouragement of employment of disabled persons

Four basic measures have encouraged the integration of the disabled in the economy; the cost of these measures is borne by the Fonds National de Reclassement Social des Handicapés:

1. A contribution to wages and social security payments for a maximum of one year is provided for by the ministerial order of 22 January 1968. This measure, with its time limit, is justified not by lower productivity on the part of the disabled person but solely by the added difficulty of training for the work due to the existence of the disability.
2. The ministerial order of 17 March 1965 lays down the conditions and arrangements for assistance with the adaptation of working facilities.
3. Provision is made for a contribution to the cost of working instruments and clothing, also in the context of the policy of employment of the disabled, by the ministerial order of 17 March 1965.
4. The ministerial order of 17 Novem.1965 provides for the possibility of loans being granted and guaranteed by the Fonds National de Reclassement Social des Handicapés. These loeans are guaranteed or granted in so far as they are necessary for the purpose of placement.

b) Employment in the public sector

1) Compulsory employment

Under Article 21 (1) (2) of the law of 16 April 1963 concerning the social resettlement of the disabled, public administrations (the civil service) and public bodies are obliged to employ a number of disabled persons (a royal order passed by the Council of Ministers is to determine the number of disabled persons to be employed). This provision has not yet been implemented.

2) Examination of physical aptitude for employment in an administration

Since employment in public administrations (the civil service) entailed substantial benefits for successful candidates, the royal order of 30 March 1939 stipulated a judicious and highly rigorous process of selection in their recruitment. The rules for admission to employment in the public service were considerably relaxed by the royal order of 1 December 1964; there is no handicap for a disabled candidate if

a) there is no danger for him or anyone else in his exercising this public function and
b) his physical or mental aptitudes allow him to perform the function.

In addition in the execution of these provisions, the executive, demonstrating its desire to achieve genuine integration in the public service, has stipulated that when a candidate is turned down, the grounds of the refusal must be notified to the Fonds National de Reclassement Social des Handicapés if the candidate is registered therewith. The Fonds National then comments on the decision taken to the Administrative health service.

France

The law of 26 April 1924 providing for compulsory employment of the war-disabled is the first enactment in this connection. It provided that employers who regularly employed more than ten wage-earners over the age of 18 had to employ war-pensioners in the proportion of 10% of their total staff. The decree of 20 May 1955 widened the scope of these provisions, extending them in particular to certain categories of war widows and orphans.

Finally, law n° 57-1223 of 23 November 1957 on the resettlement of disabled workers stipulated certain measures designed to ensure that this resettlement actually took place.

For the purpose of benefiting from the provisions of this law, a disabled worker is defined as any person whose chances of obtaining or retaining a job are effectively reduced in consequence of an insufficiency or reduction of his physical or mental faculties.

It is the Commission Départementale d'Orientation des Infirmes which decides wether a person qualifies as a disabled worker.

The law confirms the entitlement of all disabled workers to the benefit of rehabilitation, re-education or vocational training, and, for this purpose, provides for further advantages.

It requires all establishments or groups of establishments belonging to the same trade and including more than 5.000 workers to provide retraining at work and vocational re-education of sick and injured persons belonging to the establishment or group of establishments.

Public authorities, industrial, commercial and co-operative establishments and employers in the professions are bound by the law of 23 November 1957, which stipulates financial penalties.

Employment offices are responsible for the placement of registered disabled persons at their request.

Disabled persons enjoy priority of employment up to the percentage fixed by the ministerial order of 20 September 1963.

This percentage is 3% for all bodies and firms mentioned in paragraphs 1, 2 and 3 of Article 3 of the law of 23 November 1957.

Priority of employment in the public sector was implemented by the decree of 16 December 1965, which resulted in the promulgation of a number of orders stipulating the percentages applicable to the different posts in the administrations.

For farms, the percentage applies where more than 15 persons are employed.

In mines, opencast mines and quarries, the requirement applies only to surface workers.

The provisions of the order take effect throughout France on 1 January 1964 except where an order applicable to a single Department or group of Departments stipulates a different percentage for a specific activity or group of activities.

Italy

a) Private sector

1) Invalids who are the victims of working accidents and sufferers from occupational diseases

Legislative decree n° 1222 of 3 October 1947 stipulates that disabled persons and invalids who are the victims of accidents at work shall be employed in private firms. It applies to male workers under sixty years of age and female workers under fifty-five years of age who, in consequence of an accident at work or occupational disease, have sustained a permanent reduction in their working capacity of at least 33,33%. The provisions of the law do not apply to disabled persons and invalids who are the victims of accidents at work and who have lost their entire working capacity or to those whose presence, by virtue of the nature and degree of their disablement, may be prejudicial to the health and physical safety of their workmates or the safety of the installations. Should there be no invalids to be placed, firms must make up the compulsory percentages stated below by employing the orphans and widows of deceased workers.

Private firms employing over 50 workers (manual and clerical) are required to engage one disabled person or invalid, being the victim of an accident at work, for each group of 50 workers or fraction of 50 exceeding 25. Airlines and shipping lines are exempt as regards on-board personnel.

Fines are imposed on employers infringing the provisions of the decree or its implementation regulations.

2) Tuberculosis patients

Legislative decree n° 538 of 15 April 1948 provides that all sanitoria for tuberculosis sufferers with over 200 patients must engage former tuberculosis sufferers who have recovered on their staffs, in the proportion of 10% of their labour force.

The decree stipulates fines for non-observance of this rule.

3) Military and civilian war invalids

All employers in the private sector employing more than ten people are required to employ military and civilian war invalids in the proportions of 6% and 2,5% respectively of their total labour force.

Firms whose staff is mainly female are required to employ war invalids only in the proportions of 3% of their male staff for ex-servicemen, 2% of their male staff for male civilian invalids and 3% of their female staff for female civilian invalids.

Sanctions are stipulated against firms infringing the conditions and requirements of the law. The product of fines must be paid to the National Institute for the Protection and Assistance of Invalids to form a fund for the benefit of prosthetic institutions and establishments concerned with the re-education of invalids.

4) Civilian invalids

Law n° 1539 of 5 October 1962, which provides for benefits for civilian disabled persons and invalids, stipulates compulsory employment by employers and the civil service (public administrations).

Regarding private firms, this law provides that employers with staffs of over fifty manual or clerical workers, not counting apprentices, must, whenever a vacancy occurs, engage one civilian disabled person or invalid for every ten workers recruited, until the proportion of one invalid or disabled person to every fifty workers is reached, fractions exceeding twenty-five counting as fifty.

Employers may directly engage civilian disabled persons or invalids registered in the lists kept by the provincial employment offices in collaboration with the representative of the national associations of civilian disabled persons and invalids.

To qualify for registration in this list, civilian disabled persons or invalids must:

1) be under fifty-five years of age;
2) suffer from a physical deficiency reducing their working capacity by at least one third (exclusions: deaf-mutes, blind persons and civilian invalids the extent of whose disablement might constitute a threat to the physical safety and health of their workmates and the safety of the place of work);
3) submit a declaration from the Provincial Health Commission appointed at each provincial employment office certifying the existence of the physical deficiency;
4) furnish all documents required as evidence of the general or specific occupational capabilities of the person concerned.

For monitoring purposes, employers are required to send the competent local provincial employment office a statement setting out:

1. the total number of workers in their service, classified by establishments, sex and grade;
2. the number, marital status, occupational qualifications and date of engagement of civilian invalids.

The sanctions are as follows:

a) Employers who fail to submit the above mentioned statements are liable to a fine of between 5.000 and 5o.000 lire;

b) Employers failing to meet their employment obligations are liable to a fine of between 1.500 and 3.000 lire per working day and per reserved post not occupied.

b) Public sector

1) Disabled persons and invalids who are the victims of accidents at work

Law n° 851 of 14 October 1966 was published in the G.U. (official gazette), n° 265, dated 24 October 1966. It provides for the compulsory engagement of disabled persons and invalids who are the victims of accidents at work, and the orphans and widows of workers who died at their place of work, in State administrations (the civil service) and local or public Organisations.

Decree-law C.P.S. n° 1222 of 3 October 1947 provided for the compulsory engagement of this class of disabled persons only for private firms employing more than 50 workers.

Under the terms of Article 3 of the law, n° 851, disabled persons and invalids who are the victims of accidents at work may be engaged as established staff without competition, up to the proportions of 1% of the executives and 3% of the non-executive staff of the "auxiliary" category or equivalent.

These administrations are also required to engage without competition disabled persons and invalids, being the victims of accidents at work, in the proportion of 5% of the labour force of both sexes, established and non-established, for each of the categories stipulated in Article 2 of law n° 90 of 5 March 1961, after prior testing of their professional aptitude, by means of an appropriate test for the first two categories.

Should there be no invalids to be placed, Administrations must make up the compulsory percentages by employing the orphans and widows of workers who died at their place of work (Art. 12).

The benefits of the provisions of law n° 851 open to male and female workers under the age of 55 who have, in consequence of an accident at work, suffered a permanent reduction in their working capacity of at least 33,33%.

To qualify, disabled persons and invalids who are the victims of accidents at work must register with the Provincial Section of the National Association of Disabled Persons and Invalids who are the Victims of Accidents at Work (A.N.M.I.L.), after submission of a declaration issued by the National Working Accidents Insurance Institute (I.N.A.I.L.) certifying the nature of the disablement and the degree of reduction of the working capacity, as well as a duly authenticated declaration issued by a health service doctor certifying that the person concerned, by virtue of the nature or degree of his disablement, cannot harm the health or safety of his workmates and the safety of installations.

2) Military and civilian war invalids (law n° 375 of 3 June 1950, as modified by law n° 367 of 5 March 1963)

For State posts open to civil servants and accountants, war invalids who produce evidence that they fulfil the conditions laid down are engaged preferentially in the proportion of one invalid for every ten posts in the case of ex-servicemen and one invalid to every twenty posts in the case of civilians; a minimum of two posts is stipulated in each case.

The posts of clerks and junior clerical workers must be filled without competition in the proportions of 10% and 30% respectively for invalid ex-servicemen and 5% and 15% respectively for civilian invalids. The public services must employ invalid ex-servicemen and civilian invalids for manual work in the proportions of 6% and 3% respectively of the total number of male and female workers making up their labour force. For employment on the State Railways and public transport services operated on concession by private companies (railways, tramways, trolleybuses, telpher railways, inland navigation), compulsory employment of war invalids applies only to certain jobs, and different percentages are applicable (from 6 to 30% for invalid ex-servicemen and from 3 to 15% for civilian invalids): the higher percentages apply to sedentary occupations and the lower percentages to jobs requiring physical effort.

3) Civilian invalids

Deaf-mutes (law n° 308 of 13 March 1958)

Blind switchboard operators (law n° 155 dated 5 March 1965)

Blind masseurs (law n° 686 dated 21 July 1961)

Civilian disabled persons and invalids, for the "auxiliary" category (law n° 1539 of 5 October 1962)

Civilian disabled persons and invalids fulfilling the conditions mentioned above under A.- Private sector, 4), Civilian invalids, may obtain a State post, or a post in a public body, in the proportion of 2% of the jobs allowed for in the budget and in the quota.

Grand Duchy of Luxembourg

The Office pour le Placement et la Rééducation Professionnelle des accidentés du travail et invalides de guerre (Bureau for the Employment and Vocational Re-education of Victims of Accidents at Work and War Invalids) was set up by Grand-Ducal order of 26 February 1945.

All jobs under the control of the Inspectorate of Labour and Mines, which could be occupied by war invalids or invalids who were the victims of accidents at work, who had suffered a reduction of at least 50% in their vocational working capacity, were reserved for these persons on a priority basis.

Since these regulations applied only to the victims of accidents at work and to war invalids, a law was passed to extend the benefits or re-education to all physically disabled persons, wether or not insured. This was the law of 28 April 1959 concerning the Office de Placement et de Rééducation professionnelle des Travailleurs Handicapés (Bureau for the Employment and Vocational Re-education of Disabled Workers).

The law explicitly stipulates priority of employment for disabled workers in accordance with the following arrangements:

1. The State, communes, the Luxembourg Railways, and public establishments are required to reserve for disabled workers, provided that the latter satisfy the legal or regulation training and admission conditions, at least 2% of the total number of posts for wage-earning staff employed as officials, clerical or manual workers.
2. In the private sector, firms regularly employing not less than 50 workers are required to reserve for disabled workers at least 2% of the total number of posts filled by wage-earning clerical or manual staff. Firms employing not less than 25 and not more than 50 workers must grant disabled workers priority for a post to which they are particularly suited. The jobs to be reserved for disabled persons are stipulated by the Office after consultation with firm managers.

Netherlands

The law of 1947 on the employment of the physically disabled permits any disabled worker to register as such at the State employment office in the district of his residence. It stipulates a compulsory employment percentage for all firms. Another provision concerns wage guarantees for invalids who work normally.

According to the law of 1 August 1947 on the employment of invalids, this term indicates persons who, in consequence of deficiencies, infirmities or mental or physical troubles, are materially incapable of earning a living by working.

The law applies to both the public and the private sector. Organisations employing more than 20 wage-earners are required to employ at least one invalid if their total staff does not exceed 50 wage-earners and at least one additional invalid for every 50 wage-earners after the first 50; remainders less than 50 are disregarded. The law provides for the publication of regulations specifying categories of undertakings for which this proportion may be modified, and extending its provisions to certain firms employing not more than 20 wage-earners.

Fines are stipulated for contraventions or infringements of the provisions of the law.

Employers are required to provide at their firms tools and machines capable of being used by invalid workers having regard to their disablements and equipped with suitable protective devices.

C.-Employment of disabled persons

1) Determination of wages

The legislation in Germany, Belgium, France, Luxembourg and the Netherlands includes measures relating to the determination of wages.

Germany: Under the law of 3 July 1961, in the calculation of remuneration, no account may be taken of any pension received under the Federal assistance law or from social insurance.

Belgium: Workers are entitled to the wage awarded by the joint commission for his job.

France: The law of 27 December 1960 stipulates that disabled workers whose output is severely reduced may receive reduced wages, subject to limits laid down by decree.

Decree of 7 February 1964 implements these provisions in the following form:

1) Maximum reductions for different classes of disablement
2) Determination of mimimum wages below which a decision by the employment department is required.

The Commission d'orientation des infirmes stipulates where applicable the reduction which may be applied by the employer to the wages of a disabled person in accordance with his job in the firm.

There are three classifications:

A. for slight disablement
B. for moderate disablement
C. for serious disablement.

The reduction may not exceed, by comparison with the wage normally paid to a non-disabled worker doing the same job:

10% for class B
20% for class C.

Consequently, a disabled worker placed in class A may not have his wages reduced as compared with the wage normally paid to a non-disabled worker doing the same job.

However, where as a result of the reductions applied the wage offered to the disabled worker is less than the "minimum guaranteed inter-occupational wage" (S.M.I,G.) the application decision is taken:

a) by the Departmental Director of Labour and Employment (Directeur départemental du travail et de l'emploi) where the reduction does not exceed 10% of the "minimum guaranteed inter-occupational wage"

b) by the Divisional Inspector of Labour and Employment (Inspecteur divisionnaire du travail et de l'emploi) in the case of reductions exceeding 10%.

Grand Duchy of Luxembourg: Article 7 of the law of 28 April 1959 regarding the setting up of the Office de Placement et de Rééducation Professionnelle des travailleurs handicapés stipulates that the invalid shall be paid in accordance with his aptitude and working capacity, subject to the legal provisions as to the determination of a minimum social wage. If he discharges all aspects of the post to which he is admitted, he is entitled to the wage stipulated for this post. If owing to his disablement he can only partially perform his job, his wage may be reduced pro rata. If the parties fail to agree, the Office decides.

The remuneration is to be determined independently and without taking account of the accident pension paid to the person concerned by the Association d'assurances (Insurance Association) and the Office des dommages de guerre (War Compensation Bureau).

These pensions are to be paid to the beneficiaries in full; they must on no account be deducted from the pay of disabled workers, nor in any other way reduced to the detriment of their beneficiaries.

Netherlands: The law of 1 August 1947 on the employment of physically disabled persons stipulates guarantees for the wages of invalids who work normally.

2) Government grants towards pay and employers' social security contributions

Only Belgian legislation provides for government support for pay and employers' social security contributions.

A contribution by the government is payable in respect of any disabled worker, manual or clerical, who, by virtue of the nature of his disablement, experiences difficulty in adapting to his job and hence fails to achieve the normal output.

This contribution is payable for not more than one year (a maximum of 23 francs per hour for the first 6 months, reducing every three months) by:

a) the Office National de l'Emploi in the case of workers required to participate in the social security scheme

b) the Fonds national de reclassement social des handicapés in the case of other workers.

For the sake of completeness, we mention here the policy of the Grand Duchy of Luxembourg concerning social employment; this will be dealt with in detail under the heading of sheltered employment.

It may also be mentioned that in the Federal Republic of Germany, the law of 3 August 1965 concerning war victims provides for the payement of an allowance to invalids who, for a certain period after starting a new job, do not receive their full wage.

3) Adaptation of the working position

In the Federal Republic of Germany, the law of 3 July 1961 requires employers to equip and maintain workshops, plant, machinery and tooling, and to organise work, in such a manner as to take particular account of the risks of accident, to enable as many invalids as possible to be employed on a continuous basis. Employers are also required to equip the workshop with the essential technical accessories. These requirements are not applicable if compliance therewith were to cause serious damage to the firm or involve excessive expenditure, or if the workers' protection requirements laid down by the State or by the trade associations conflict therewith.

In all firms and administrations having a staff committee, the latter is obliged to encourgae the employment of invalids and to endeavour to obtain for them a job suited to their capacities and knowledge. In all firms or administrations occupying not less than five invalids, other than on a temporary basis in reserve posts, these wage-earners must elect a delegate responsible for defending their interests, who must himself be an invalid.

In Belgium, the law of 16 April 1963 provides that the Fonds National de Reclassement Social des Handicapés will meet the cost of adapting the working position to the disability of the person concerned.

The cost met represents, in the case of adapted equipment (e.g. a telephone switchboard), the difference between the adapted equipment and the standard equipment (ministerial order of 17 March 1965).

In the Netherlands, under the law of 1 August 1947, employers must provide at their works tools and machines adapted for operation by disabled workers and equipped with appropriate protective devices.

4) Contributions to the cost of working clothing and tools

The Belgian legislation of 16 April 1963, and more particularly the ministerial order of 17 March 1965, provides that the Fonds National de Reclassement Social des Handicapés shall contribute to the cost of working clothing and tools where these are essential to the disabled person and where the employer is not required to assume these costs.

5) Social aid facilitating access to employment

In the Federal Republic of Germany, the law of 23 February 1957 on pension insurance includes as one of the benefits social assistance aimed at safeguarding, improving and restoring the faculties of gainful activity.

In addition, the Federal law on social assistance, revised on 18 September 1969, provides for assistance for the purchase of a motor vehicle where this is essential for the resettlement of the person concerned.

In Belgium, the law of 16 April 1963 stipulates that the Fonds National de Reclassement Social des Handicapés is to make a contribution to social aids which will assist the return to work of disabled persons. The Fonds National thus contributes to:

a) adaptation of a motor vehicle
b) provision of a mechanically or electrically propelled invalid carriage
c) exceptionally, travelling expenses, where these constitute an exorbitant burden for the disabled person.

6) Other facilities not dealt with under the previous headings

In the Federal Republic of Germany, under the law of 21 February 1964 on aid for war victims, grants may be awarded for the purchase, maintenance and adaptation of motor vehicles, and for garaging costs for motor vehicles and invalid carriages and for the cost of accomodation of guide dogs for blind persons; it is also possible to obtain a contribution to the cost of certain personal and other services.

In addition, under the law of 3 July 1961 on the employment of invalids, invalids are entitled to an additional paid holiday period of six working days per annum.

D. - Organisation of placement

In the Federal Republic of Germany, the law on the promotion of employment of 25 June 1969 charges the Federal Labour Office of the Ministry of Labour and Social Affairs, through the network of regional offices, with the placement of disabled persons.

These offices determine the relevant employers and their quota obligations and effect the placement of disabled persons.

In Belgium, placement is effected by the Office National de l'Emploi, set up under the law of 28 December 1944 on social security. This Office, through its regional branches, which have specially trained staff for problem cases, effects the placement of disabled persons.

When a disabled person has been trained or rehabilitated under the terms of the law on the social resettlement of disabled persons, the Fonds National requires him to be registered as seeking employment at the regional branch of the Office National de l'Emploi.

It is again pointed out that implementation of the legal requirement to employ a quota of disabled persons is still pending.

In France, employment offices are responsible for the placement of registered disabled persons at their request, whilst pursuant to the ministerial order of 2o September 1963 application of the employment priority rule is the responsibility of the Direction Générale du Travail et de la main-d'oeuvre of the Ministry of Labour.

In Italy, the placement of the victims of accidents at work and of "service invalids" (as defined in the law of 24 February 1953) is effected by provincial commissions under the chairmanship of the Director of the regional or provincial employment offices.

The provincial employment offices are responsible for the application of the law of 5 October 1962 concerning the compulsory employment of civilian disabled persons and invalids.

In the Grand Duchy of Luxembourg, the Office de placement et de rééducation professionnelle des travailleurs handicapés is responsible for the placement of disabled workers.

In the Netherlands, the "State employment bureaux" are responsible for applying the provisions as to the employment of disabled persons; however, as regards "social employment" local commissions have been set up for the application of this policy. Representatives of the recognised trade unions sit on these local commissions and on a central commission which reports to the government.

E. - Sheltered employment

Legal provisions have been enacted in three countries of the European Community for the organisation of sheltered employment: Belgium, France and the Netherlands.

In Belgium, the law of 16 April 1963 lays down rules for the approval of and the award of grants for the setting up, laying out, equipping and operation of sheltered workshops.

By virtue of the royal and ministerial orders of 23 March 1970, the government has laid down minimum wages for workers employed in sheltered workshops, and the government has also established the amount of the contribution of the Fonds National de Reclassement Social des Handicapés to the wages of the disabled worker.

This contribution generally amounts to 65% of the pay. This rate is, however, increased, sometimes up to 100%, in the case of severe disablement.

Regarding the setting up, laying out and equipping of sheltered workshops, the Fonds National contributes 60%

of the cost of these structures, works or purchases.

In France, the law of 23 November 1957 on the resettlement of disabled workers includes provisions relating to sheltered work.

Under the terms of Article 23 of this law, disabled persons whom it is impossible to place in a normal working environment may be admitted either a) to an "aid through work" centre as defined in the Code de la famille et de l'aide sociale (Family and Social Aid Code) or b) in a sheltered workshop.

In addition, workshops known as "home-work distribution centres" may provide work to be carried out at home by disabled workers.

Sheltered workshops and home-work distribution centres may receive grants, particularly from the State, the Departments and the communes, as well as from social security bodies, in pursuance of the law of 23 November 1957. An agreement must be concluded whenever such a grant is awarded.

In the Netherlands, the different forms of sheltered employment are regulated by the law of 23 November 1967 on sheltered employment.

The 1967 law on social employment stipulated that in future the government would assume responsibility for the creation and continuance of jobs suited to all disabled persons requiring them.

The need for "suitable jobs" increases with the number of persons whose chances of survival were slight at birth or whose state of health has substantially deteriorated at a more advanced age, but who are able to resume active life thanks to the new possibilities afforded by medical science, in particular in the field of rehabilitation. However, since the exercise of an occupation under normal conditions is too arduous for many of these persons, suitable employment must be provided for them.

Apart from these socio-political considerations, the government also considered it necessary, in view of the extensive nature of social employment, to make legislative provisions to govern the relations between the central government, local authorities and voluntary organisations, combining to settle the details of applications of social employment.

The financial relations between the government and voluntary organisations are also to be fixed by legislation. The relevant law codifies the rules and directives on social employment which, with a large number of amendments, had been set out in ministerial orders for manual and non-manual workers. On certain points, for example control of wages, working hours and ancillary conditions of employment, the law stipulates basic principles, whose detailed application will be by way of orders.

The law defines "social employment" as "the provision of a specially adapted job designed as far as possible to maintain, restore or improve the working capacity of persons fit to carry on an occupation but unable to undertake employment under normal conditions mainly by reason of personal factors". This definition is an indication of the aim of social employment, which is to increase working capacity by occupational activity (rehabilitation).

Responsibility. It is the responsibility of the central government to see that sufficient job possibilities exist, and hence to organise these. The law provides that an active part is also to be played by local authorities, which are charged with the promotion of such job possibilities. This means that the local authorities are responsible for naming persons likely to benefit from placement in sheltered employment and it is also up to them to create suitable jobs or to encourage the creation of social employment by other bodies.

Local commissions have been set up for the application of this policy, and the government is advised on general questions by a central commission.

The central government contribution to the cost of social employment is considerable. The rate of support has been fixed at 90% - 75%, and more substantial funds are devoted to the development of industrial medical services and the training of managers, etc. 50% of the workers' wages are subsidised by the State.

III. - National bodies responsible for co-ordination

Item 13 of the recommendation on invalid rehabilitation policy of the Brussels Treaty Organisation, now the Council of Europe (Partial Agreements) stipulates:

> It is important to establish close links between the various bodies concerned with rehabilitation and re-employment, such as national or regional administrations and voluntary organisations, but especially between the different medical and other staff groups occupied directly with rehabilitation. Co-operation must be encouraged on the national and regional levels; it is desirable for each country to have a central co-ordinating body.

This provision concerning the setting up of a central co-ordinating body has been put into effect with a greater or lesser degree of success in each Community country.

In the Federal Republic of Germany, all the current laws on social matters, where these contain provisions on the integration and reintegration of invalids into active life, as well as laws in preparation relating to this field, require the competent authorities and public institutions to work together in close co-operation in order to ensure the success of their joint efforts to integrate and re-integrate the physically disabled into active life and the

the community. The authorities involved in the application of these measures have jointly adopted approaches designed to ensure effective co-operation. This approach has given satisfactory results in practice.

With the passing of the law on the promotion of employment of 25 June 1969, effective from 1 July 1969, the Federal Ministry of Labour and Social Affairs became responsible for the whole range of social security, arrangements for aid to war victims and the protection of the severely disabled. The Ministry, together with the other Federal ministries and the Länder authorities will endeavour to co-ordinate vocational rehabilitation measures. By virtue of its staff and organisation, the Federal Labour Office occupies a key position in the field of vocational rehabilitation. It provides the specialised services which are essential to the success of rehabilitation, and by its extensive network of regional branches and placement offices provides direct access to the labour market.

Federal Working Group on Rehabilitation

The Federal Working Group on Rehabilitation was set up on 31 March 1969. This body links together the central sickness insurance, retirement insurance and accident insurance organisations, the Federal Labour Office, the Länder, the Federal Working Group of Inter-regional Social Aid Bodies, the German Confederation of Employers' Associations, the German Federation of Trade Unions and the German Union of Wage-earners.

Under the terms of its statutes, the Federal Working Group on Rehabilitation is responsible for the co-ordination and promotion of measures in the field of medical, vocational and social rehabilitation.

Information Centre for Rehabilitation Establishments

The Information Centre for Rehabilitation Establishments, which operates in the Heidelberg Rehabilitation Centre by decision of the Federal Ministry of Labour and Social Affairs, organised the first training and further training course for vocational rehabilitation specialists, starting in autumn 1969. This course was followed by the staff of rehabilitation establishments and specialists from various rehabilitation instututions; further courses are to be held at a later date.

In Belgium, the law of 16 April 1963 on the social resettlement of the disabled stipulates the following as the main functions of the Fonds National de Reclassement Social des Handicapés:

1. Co-ordination of existing activities to prevent the dispersal of initiatives by effective and concerted action at national level; these co-ordination measures fall into three groups:
   a) the drafting of a rehabilitation programme falling within competence of the Fonds National, to prevent duplication with other legislation;
   b) co-operation with the various public and private bodies and institutions concerned with rehabilitation;
   c) the setting up of rehabilitation centres or services where not provided by public or private initiative.
2. The promotion of the rehabilitation and social resettlement of disabled persons:
   a) by co-ordination of the rehabilitation measures to be taken, through its powers of jurisdiction;
   b) co-ordination of the activity of the various rehabilitation centres and services;
   c) supervision of the engagement of disabled persons in conjunction with the competent ministerial departments.

In France, joint measures have been adopted over the last few years by the competent ministerial departments to lay the foundations for a co-ordinated organisation to form a framework for the activities of the different services and institutions. One of the provisions of the law of 23 November 1957 on the resettlement of disabled workers was the setting up of a "Conseil Supérieur pour le Reclassement Professionnel et Social des Travailleurs Handicapés (Senior Council for the Vocational and Social Resettlement of Disabled Workers) having the following field of competence:

1. Promotion of public or private initiatives in the following fields:
    - Pre-education
    - Functional rehabilitation
    - Vocational rehabilitation and placement
    - Organisation of sheltered employment
    - The teaching, education and preparation for work of disabled children and adolescents
    - Facilitating the co-ordination and supervision of these initiatives.
2. Obtaining comprehensive data by means of surveys, censuses and statistics on these problems, concerning in particular job possibilities;
3. Encouraging the setting up and working of research and experimental organisations and recovery and resettlement centres;
4. Acting in a consultative capacity to the government in connection with laws and regulations relating to disabled persons;
5. Establishment of a climate of opinion favourable to resettlement through the press, radio, television and other appropriate media.

In Italy, the need for national co-ordination of all activities relating to the rehabilitation of the physically disabled (including persons with sensory deficiences) and the mentally handicapped has induced the Ministry of Health to set up a central division, within the framework of its own departments, responsible for encouraging and harmonising the different activities in question, in accordance with uniform directives based on the progress of modern rehabilitation techniques,

In the Grand Duchy of Luxembourg, there is no co-ordinating body as such. As to the practical application of rehabilitation measures, co-ordination is in fact effected through the "steering committee" of the Office des Travailleurs Handicapés, on which the main State or para-State bodies and the employers' and workers' organisations are represented.

In the Netherlands, the various activities on behalf of the disabled were linked together in 1954 by the Council for Rehabilitation, set up by the Ministers of Social Affairs and Public Health, Defence, Social Assistance and Education, and Arts and Sciences. This Council, which includes representatives of the above ministries and of private rehabilitation organisations, is a consultative and co-ordinating body. Its advice is sought, in particular, on the measures to be taken in the field of social medicine and in order to encourage the development of medical and social assistance afforded to invalids by private organisations and establishments.

Conclusions

At the end of this study of some of the legislative enactments relating to the social resettlement of the disabled, it is encouraging to note the dynamism of each of the national legislations in this field.

It is obvious that each government feels in duty bound to assure the disabled of a place in the economic potential of the nation.

Wether the needs were human, social or economic, each country has over the last twenty years developed the facilities available to the disabled.

At this European meeting, we consider it appropriate to formulate two aims to be striven for.

Firstly, there should be provisions in all Community countries to gurantee all disabled persons - regardless of their status and the cause or origin of their disablement - the right to functional and vocational rehabilitation and to work, either in normal working conditions or under sheltered conditions.

Secondly, once each country has reached the same level, not only in legislation but also, and in particular, in the facilities offered, each citizen of any Community country should be able to be rehabilitated and reintegrated anywhere in the European Community.

It is hoped that this study will contribute to the achievement of these aims.

Dr. VELDKAMP

1. The problem considered from the de lege ferenda viewpoint

The problem of the resettlement of the disabled, in terms of the legislation of Member States of the European Communities, can be dealt with either from the point of view of existing legislation or from that of legislation needed. I shall examine the question here from the latter point of view.

If we look at the way in which legislation on the disabled has evolved in most western countries, we can see that it has followed substantially the same trends as social legislation in general. In its initial phase, social legislation consisted of laws to provide for exceptional cases. It afforded special protection for all those who were faced with unusual difficulties. You may recall that the first labour legislation was primarily designed to protect children and women and, insofar as it covered adult male workers, it was usually concerned with work done in special circumstances, with particular reference to dangerous jobs.

Although social legislation has undergone considerable development since, and has now, generally speaking, outstripped its initial protective function, the social legislation of most western countries to this day still shows many traces of the "exceptional-case" philosophy which characterised it initially. This seems to me particularly true of legislation on the disabled. The legislators have approached the problems of the disabled mainly through legislation on insurance against industrial injury. The principle that a worker who is the victim of an accident or contracts an equally disabling occupational disease either in the course of his work or in connection with his employment, should be compensated as fully as possible at the expense of his employer, has always formed an important element in legal thinking on this subject. His occupation was after all the cause of his becoming unfit for work. It should form part of the firm's normal overheads to compensate such persons as fully as possible. This was done first mainly by providing them with a compensatory incone, but gradually it also became the practice to give them training which might make it possible to reemploy them either in their old job or in a different one. This idea has received considerable backing from the conventions of the International Labour Organisation.

It must, however, be borne in mind that this legislation for the disabled was, and still is, basically legislation for the exceptional case, and remained restricted to persons in special circumstances, namely persons who, either at work or in connection with their jobs, have an accident or have contracted an equally disabling occupational disease. As Mr. MARON has demonstrated in his paper, the legislators have not been idle in this field; regulations have also been framed in the various countries for persons who have not been victims of an industrial accident or contracted an occupational disease. But even a superficial survey of this legislation reveals the considerable difference between workers who have been victims of industrial accidents or have contracted equally disabling occupational diseases, and others, wether workers or not, for whom that is not the case.

2. From the principle of causality to that of finality

When the question arises as to what the most desirable legislation should be concerning the disabled, one should, of course, from the outset, ask oneself wether it is fair that a distinction should be made between workers who have an accident or have contracted an equally disabling occupational disease at or in connection with their work and workers or non-workers who become disabled through other causes. In other words, is it right to maintain this principle of causality which forms the basis of the distinction in the legislation, or should it be abandoned?

It seems to me that there is every reason to abandon it. After all, it only satisfies the individualistic, economic view of the disabled and is a corollary to liability in private law for a wrongful act. An accident has taken place during work or in connection with the job; this means that whoever is responsible for the conditions under which the work is done, should also bear the consequences flowing from this aspect of the employment. This conclusion may be of importance in the question of who is to pay compensation, although even this may be called into question by modern theorists who regard the problems primarily from the point of view of the enterprise in which the job has the function of a production factor. The theories are not based on the life aspect of the job. A man works in order to live and does not live in order to work. This life aspect applies to any handicap and not only to those which have their origin in or in connection with employment in an enterprise.

If the problems are examined not from an individualistic point of view but from a social one, then it should be clear that, in social terms, it is of no importance how a handicap arose but the mere fact that a handicap has arisen. The main aspect of this attitude is that anyone who is disabled cannot maintain himself through work and that it is therefore necessary from a social point of view to make adequate provision for him. Thus the guiding principle should not be that of causality but that of finality.

Looked at from this point of view it seems hardly relevant wehter an accident victim incurred his accident during or in connection with his work, or wether the accident occurred outside working hours and not in connection with the job. It is equally irrelevant to distinguish between a person who worked for wages and one who worked but not for wages. And it would even seem irrelevant to distinguish between one who has become unfit for work while performing an economic function in society and one for whom this is not the case. Everyone is basically subject to the same needs wether from the point of view of earning an income or from the point of view of doing a job, and this is the important factor in resettlement. I should like to pause for a moment and consider these three points in greater detail.

a) With regard to the distinction between accidents which take place during work or in connection with the job and accidents which do not take place under these circumstances, it should be noted that, if the causal principle is strictly applied, real cause of the accident must obviously be analysed. You must all be well aware of the fact that the literature unanimously regards the vast majority of accidents which take place at work or in connection with work, as not being the result of hazards connected with the work as such but of factors connected with the individual and the circumstances under which he lives and works. If this causal principle were strictly applied in the case of many accidents, there would be no compensation whatsoever. Indeed, if the causes of accidents are analyzed, the following factors are seen to be of importance:

1) the nature of the enterprise;
2) factors of a material nature (installation and maintenance of factories and workshops, tools and equipment belonging to them, knowledge of the nature and quality of machines and loose equipment);
3) working conditions (temperature, atmospheric conditions, lighting, place of work);
4) causes connected with the relations prevailing in an enterprise;
5) the attitudes of both management and workers in an enterprise towards questions of safety;
6) individual factors concerning the employee (physical and psychological state, fitness for a particular type of work, fatigue, duration of the employment, age, personal disposition to accidents, use of alcohol, sense of cleanliness and tidiness, acclimatisation).

Individual factors are of particular importance. It is often the same people (or the same type of people) who, as it were, seem to attract accidents. On the other hand, it is a fact that many accidents, which do not take place at work or in connection with work, have their origins in circumstances connected with the job or with working conditions. The one invariable factor is that somebody has become unfit for work and hass need of compensation and under certain circumstances needs rehabilitation.

b) Why a distinction should be made between persons performing work under a contract of employment and those performing work but not under a contract of employment is not at all clear. Wether the problem is approached from the point of view of the causality or finality, there is little reason to make a distinction between the two groups. In many countries there has for many years been a violent dispute as to wether social security should be restricted to those performing work under a contract of employment. It can, however, be stated with certainty that, especially during recent years, the differences between the two bodies of opinion have become smaller.

c) Finally, there is the category of those who do no work at all in the sense of being integrated in the economic system of work for remuneration. Three categories may be distinguished here. Those who do not as yet work; those who no longer work and those, such as housewives, who are not integrated into the economic system of work for remuneration, but nevertheless work. As regards the last mentioned category, the view that the housewife performs no economic work is outmoded and here again it is impossible to understand, from either the causality or finality point of view, why she should not be compensated in the same way as other groups in society who do work in the economic sense. There remain the categories of people who do not yet work or no longer work, the young and the old. The causality principle offers no solution in either of these cases. But let us take a look at the finality principle. The young still have their lives before them: irrespective of wether they were already handicapped in their mother's womb (Thalidomide babies) or wether they became handicapped before they were able to enter working life, sooner or later they become adults and find themselves in the same boat as other disabled adults whose handicaps originate in their employment. Their needs are exactly the same as those of other disabled people and require satisfaction in the same way, i.e. the chance of self-fulfilment by working for a living and rehabilitation. It is difficult to see why there should be any discrimination between these two groups. Finally we come to the aged. Generally speaking they are well provided for, or at least should be well provided for through the normal pension system. But what of the rehabilitation and resettlement of elderly disabled people? Thosw who think in strict economic terms will probably say that this group no longer requires retraining and resettlement in order to play a part in society. The question arises, however, of wether they are not morally entitled to rehabilitation and to suitable provisions to enable them to live a normal human - and therefore social - life. I would have thought that the question answers itself quite categorically.

3. The new legislation

I therefore think that the finality principle should form the basis of legislation to be prepared. This means that our legislation - and we should allow ourselves to be guided in this by the conventions of the International Labour Organisation - needs to be redrafted around the principle that it should apply directly to all citizens; that, on the one hand, all citizens should be entitled to compensation for the income they would be able to earn if they were not disabled and, on the other hand, that the most comprehensive rehabilitation facilities should be available to them. I realise that for many countries this would be a great step forward. In the first place it means that the distinction maintained in workers' insurance between industrial injuries insurance and disablement insurance would have to be abandoned. In terms of social policy this involves great difficulties in that generally speaking - as I have already explained - industrial injuries insurance usually contains much better provisions than disablement insurance.

But I believe that it is possible to take this step forward. In the Netherlands we have already done so. Of course, we cannot lower the level of compensation to those who, before the new general scheme came into force, began to draw benefits under the old industrial injuries insurance act. It is an old-established principle in social security legislation that acquired reights must be respected. This must remain the case in any reform of legislation on the disabled. But while one must respect rights which have already been acquired by persons who became disabled before the new scheme came into force, this does not mean that we cannot institute new provisions for new cases. When every body realises what adequate social policy provisions mean for all concerned and when we realise that the proportion of the total of accidents which occur in connection with employment is very small, we must decide what the best course of action is. In the Netherlands we have already made our decision and have deliberately opted for a general scheme which, though intended eventually for general application, was initially restricted to wage earners.

Before 1st July 1967 there were in the Netherlands, apart from the sickpay insurance provisions embodied in the Sickness Act, five laws covering industrial disablement insurance, namely the Industrial Injuries Act 1921, the Agriculture and Market Gardening Injuries Act 1922, the Seamen's Injuries Act 1919, the Disablement Act and the Mineworkers' Disablement Act. Up to that time there had been considerable disparity between the entitlements of those who had suffered an accident within the meaning of the accident insurance legislation and of those whe had been victims of an accident occuring in connection with their employment but were insured under one of the two disablement acts. Generally speaking it can be said that payments and other entitlements under the accident insurance provisions were generous, while this was not the case with payments made under the provisions of the disablement acts. This is attributable to the principles underlying the two groups of legislation. The accident insurance acts were intended to provide compensation for loss of earnings, and the guaranteed payments were related to the wage previously earned by the accident victim. The disablement acts, on the other hand, were not based on the principle of compensation for loss or earnings. The payments under these acts were drawn from the funds built up from the premiums paid in by insured persons and consisted of fixed amounts of money which did not change over the years to keep pace with changing trends in wages and prices. Although during and after the second world war the payments were adjusted at the expense of the State by a system of supplementary benefits, and although an interim arrangement for those drawing disablement pensions was introduced as a precursor to the Industrial Disablement Act, which provided those entitled to these pensions with payments at a level which could be regarded as a social minimum, there was a considerable difference, even allowing for the adjustments, between payments under the accident insurance legislation and those provided by the disablement insurance acts. The accident insurance acts, however, provided payments as a percentage of the victim's wage, whereas the interim arrangement took as a basis for all payments the wage of an unskilled worker.

This difference was noticeable in the case of persons drawing disablement pensions - if they were in fact entitled to benefits under the Sickness Act - after the maximum duration of payment from the compulsory sickness insurance fund had elapsed, i.e. after one year. These differences were increasingly felt to be unjust. After the Social and Economic Council had in 1957 recommended a new disablement insurance system whereby all disablement compensation payments would be set on an equal footing with those made under the terms of the accident insurance legislation, the Social Security Council's later idea was to merge the three accident acts and the two disablement acts into an entirely new legislative provision which would provide workers with an income in the event of extended unfitness for work (i.e. longer than one year) irrecpective of the cause of their unfitness for work and without the cause having any bearing on the level of payments. The Social and Economic Council - whose advice the Netherlands Government must seek on all important social and economic policy questions- agreed with the concept of disablement insurance set out in the report of the Social Security Council in 1960, whereupon I embodied this concept - which I had years previously defended in the literature - in a new law. This law governs both the payment and rehabilitation aspects. On the basis of article 80 of the Disablement Insurance Act, the trade association for each industry - which in the Netherlands operates all workers' insurance funds, apart from the children's supplementary benefit fund and the sickness insurance fund - is authorised to include certain persons who may receive help in maintaining, restoring or improving capacity for work, medical and therapeutic help and services which may improve their living condition. The persons concerned here are : those insured, those who have been insured, those who have completed the waiting period of 52 weeks and those who receive or have received disablement benefit. The law expressly assures that the right to rehabilitation as such is laid down in other legislation, namely that covering medical care, the Sick Pay Act and in the General Act on Special Sickness Costs. Those entitled may only qualify for benefits insofar as they are not already provided under section 8, §2, of the Sick Pay Act or section 6, §2, of the General Act on Special Sickness Costs.

On the other hand there is no doubt that the legislators intended that the right to rehabilitation is to be provided - even if only as an alternative - in the Disablement Insurance Act. This is, for example, clear from the terms of Article 60, §5, which authorises the judge to decide wether complete or partial rejection by the trade association of an application submitted by or on behalf of the disabled individual for application of the benefits provided is justified. If, subsequent to the granting of benefits, it becomes apparent that the person concerned cannot work or is only partially fit for work and, for this reason, suffers loss of income, he is entitled to payment of a supplementary allowance during the benefit period. The supplementary allowance is equivalent to the amount of wages lost, with the proviso that the supplementary allowance, or, if disablement benefits are being drawn, the supplementary allowance plus the latter should not exceed the maximum daily wage rate recognised by Dutch social security legislation. The National Health Service, the statutory representative of all the trade associations, plays an important part in the procedure under which the benefits are granted and kept under review.

As already pointed out, the provisions at present in force are restricted to wage earners. In January 1957 the Social and Economic Council announced that, when the old disablement insurance system was reformed - later to be merged into the system of general disablement insurance - only wage earners should be covered. But the fairness of this point of view was called into question five years later. On 24th August 1962, I was able to point out on behalf of the then Cabinet, in my memorandum to the Social and Economic Council, instructing it to report on long-term social security policy, that the disablement insurance which was then in preparation would make provision for wage earners but not for non-wage earners, namely for self-employed persons and those who had been disabled since childhood and had never been able to work. I pointed ou that an extension of the insurance coverage would make it possible to provide benefits for the self-employed group in the new legislation. In particular, I was unable to see why the self-employed could not be insured the same way as wage earners for benefits over an extended period in the event of sickness and accident, in other words in the event of a long period of unfitness for work. I realised that there was a difference where short-term benefits were concerned because, in the event of a short period of temporary disablement equivalent to the period during which wage earners would be able to draw sickness benefit in the legislation in preparation, many self-employed persons would be able to continue their business of profession. But if the disablement is so serious as to be of a more lasting nature, it is in most cases impossible for the person concerned to continue his business or professional activities, or at least not on the same footing as before, and the self-employed person thus finds himself in similar social circumstances to the wage-earner, who has become unfit for work. I pointed out in my Memorandum that there would be no objection within the Government to an extension of the scope of the disablement insurance provisions, but that the introduction of disablement insurance for wage-earners should not wait for a report from the Social and Economic Council on this subject. I noted that this would not solve the question of benefits for the disabled who had been incapable of work since their childhood. In this connection I asked wether it would not be advisable to restructure the disablement insurance system into an insurance scheme covering the population as a whole. Some distinction could be made between persons who had been disabled since childhood and those who had become incapacitated during their working life. This difference in treatment would relate both to the general level of payments and to the possibility of reducing to a certain extent payments for persons disabled since childhood who, at the expense of the national insurance scheme for the chronically ill, enjoy treatment and/or care in a specialised institution.

On behalf of the Cabinet of the day (the de Quay Cabinet), I said that expenditure for which the State was and still is responsible should of course continue to be its responsibility.

Subsequent to my request to the Social and Economic Council, brought out its report on disablement insurance for persons other than wage-earners in December 1965. The Council recommended that the insurance system for wage-earners should not be restructured into a national insurance scheme, but that a separate scheme for insurance against unfitness for work should be instituted for the self-employed and that this should be in the nature of a basic provision.

During my term of office, which ended in April 1967, I was unable to take any final decision on this important question. The Government of the day wanted to submit a bill to Parliament while it was still in power, which would provide insurance against unfitness for work for the population as a whole. Unfortunately the Social and Economic Council was unable to bring out its report in time.

This brings me to the second important point concerning the reasons why many countries will find it difficult to take this step forward. Strict adherence to the finality principle means that no distinction must be made between a worker earning wages, a non-worker earning wages or a person who does not work at all. Adoption of the finality principle means that a deliberate choice has to be made in favour of a general insurance system for the population as a whole. I realise that in many countries things have not reached that stage and I also realise that the immediate achievement of this objective would be extremely difficult economically. This also proved to be the case when the matter was being discussed in the Netherlands, where it will not be possible for some time to apply the new provisions of the Disablement Insurance Act fully to non-wage earners.

We want to make a start on the preparation of a general insurance scheme for the population as a whole based on the provisions for general old age insurance, general widows' and orphans' insurance and the General Act on Special Sickness Costs. It would be of great value if other countries were to take this step and strive towards the ultimate goal by means of a staggered programme.

Thirdly, it seems to me to be a logical consequence of the choice of the finality principle that the opportunities for rehabilitation should be increased by good legislative provision for sheltered work places and by compelling industry to employ retrained disabled people.

Fourthly and lastly, we come to a very important point. If we intend to apply the finality principle completely - I anticipated this when I mentioned the problems of disabled old people - we should not only concentrate on provisions for the disabled which are based on resettlement in the working environment, but should also consider provisions which make it more possible for the disabled to take their proper place in society. There are many cases of disabled people who cannot be rehabilitated for a return to work, but whose lives can be made more human and who can be better integrated into society by suitable measures, which in many ways are similar to themeasures which are necessary to resettle other disabled people into working life. If we are to be consistent in our application of the finality principle, we must also incorporate these provisions into the legislation. In the Dutch Disablement Insurance Act, these provisions have in fact been taken up, although I cannot say that I am altogether happy with the manner in which the provisions have been applied in practice.

4. I now come to the end of my account. As a legislator I consciously opt for the finality principle in preference to the causality principle. I make this choice because I am of the opinion that the finality principle, as a basis for legislation to provide for the disabled,reflects two important, fundamental rights: on the one hand the fundamental

right to work and on the other hand the fundamental right to health or, to put it another way, the right to medical care. I am of the opinion that both these fundamental rights are absolute, that both apply to every citizen in society, because both aim at ensuring the greatest possibilities of self-fulfilment for every man and the creation of the greatest chances for a happy life in human society.

DISCUSSION

A. MERCKLING

In connection with what has been said today, we should like to inform the participants to this Symposium that the Association Européenne pour le traitement et la réadaptation des traumatisés craniens (B.C.E.) (European Association for the treatment and rehabilitation of persons suffering from brain lesions) is building a "European pilot centre for the treatment and re-education of persons suffering from brain lesions" at Hochfelden near Strasbourg.

The aim of this centre is to put into effect the recommendations made by the Council of Europe (Mixed Commission for the rehabilitation and re-employment of the incapacitated) in 1960, this having now, ten years later, become a top priority. It is also intended as a centre for research, the exchange of information, and courses for medical and para-medical research. It will in no way trespass on the preserves of existing establishments, to which it will on the contrary offer a permanent link for meetings and refresher courses.

We should like the ECSC to offer its patronage to this institution, and invite all specialists and technicians who are concerned with these problems to communicate with its chairman, Prof. A. WACKENHEIM - C.H.U., Strasbourg.

To save time, our Association will send a communication on this subject to the Secretariat of this symposium, with a request for its publication. I draw your attention now to the series of articles on post-traumatic deafness for the N.E.

Rehabilitation of Persons Suffering from Brain Lesions

In 1960, the Mixed Committee for the rehabilitation and re-employment of the incapacitated adopted a recommendation and circulated it to all the member countries of the Council of Europe.

This recommendation defined the principles governing the early treatment of brain lesions, stressed the need to create and perfect specialised rehabilitation centres, described the staff and equipment needed for the operation of these centres and the essential conditions for occupational and social rehabilitation, the detection of psychological effects and the prevention of brain lesions, etc..

THE COMMITTEE

REALISING the importance of rehabilitating persons suffering from brain lesions and the gravity and special nature of their infirmity, the large number of persons affected, the hazards of work and the constantly increasing hazards engendered by modern means of transport, and

RECOGNISING that thus far insufficient attention has been given to the rehabilitation of those suffering from brain lesions,

BELIEVES that the general principles enunciated in the collective report and in the complete report by the experts should receive the attention of the member countries of the W.E.U., and therefore insists that henceforth these principles should be closely followed;

INVITES all the governments concerned, when adopting national measures for the rehabilitation of persons with brain lesions, to bear in mind the proposals and recommendations of those reports, in order to achieve the complete and satisfactory occupational and social rehabilitation of persons suffering from brain lesions;

RECOMMENDS governments to give a wide circulation to these reports.

Ten years after, now that the number of brain lesion cases is increasing alarmingly everywhere and the variety, gravity and special nature of the after-effects has frequently been emphasised (classification of Dr. J. Debauchez and Dr. J. Bourgade):

1 - Subjective syndrome only
2 - Neurological syndrome (various forms of paralysis)
3 - Psychic syndromes (nervous psychoses, insanity, with all their repercussions on social life and a man's occupation)
4 - Vertigo and impaired sense of balance
5 - Objective hearing troubles
6 - Disturbed vision
7 - Epilepsy and epileptic equivalents

there has been set up an "Association Européenne pour le Traitement et la Réadaptation des Traumatisés Craniens (European Association for the treatment and rehabilitation of persons suffering from brain lesions), its purpose being to give effect to the Mixed Committee's recommendations.

Its registered offices are at Strasbourg.

The Association proposes:

- to promote collaboration and mutual aid at European level in all fields relevant to cerebral, medullar and similar lesions, whatever their origin.
- to collaborate with the authorities and with public and private institutions and any other persons or corporate bodies in order to coordinate the activities proposed and undertaken with a view to developing and perfecting means for the diagnosis, treatment and social and occupational

rehabilitation of persons suffering from cerebral, medullar and similar lesions.

- to organise information meetings and refresher courses for medical, para-medical and social-service staffs who are concerned with the problems facing persons suffering from brain lesions.
- to build up a scientific, technical and administrative documentation centre for the purpose of:
  1. centralising medico-technical and sociological information;
  2. working towards the harmonisation of the terminology employed in the various European countries in the field of cranio-cerebral and medullar traumatology.
- to encourage and promote all types of research into the various aspects of this branch of pathology.
- to encourage the setting up and assist in the running of establishments for the treatment of sufferers from lesions of this type, and in particular to create in the medical district of Strasbourg (preferably near the city, in order that it shall be possible to make use of the facilities and installations of the C.H.U. of Strasbourg) a centre for the diagnosis and treatment of the complaints and ailments that may arise in the short or long term from damage to the cranium, brain, spinal column and spinal marrow or their associated parts.

A symposium was held atVALLENDAR (RFA) on 31st January 1971 at which there were assembled specialists and government observers from seven European countries (Austria, Belgium, France, Italy, the Netherlands, Spain and West Germany). The motion adopted at the conclusion of the symposium was to the effect that those present unanimously recommended the building at the earliest possible date of a European Pilot Centre on the site belonging to the Association at Hochfelden near Strasbourg, specialising in research on brain lesions and the treatment and rehabilitation of persons suffering from these conditions.

The scientific commission, under Dr. LAFON, has also compiled a report on post-traumatic deafness which appeared in the review "Médecine Européenne". A report on epilepsy and the epileptic equivalents, and another on subjective and post-commotional syndromes are in preparation.

Finally, the Commission for the Comparative Study of Laws has tackled the following problems:

- the exchange of disabled persons between European countries (an extension of the agreement on the exchange of the war-wounded),
- the application to the war-disabled of Form E6 in cases of temporary residence in another member country (see Written Question of 20th March 1971, J.O./AN - France),
- the more effective application of the legislation governing "reserved occupations",
- recognition of national reduced-fare passes by the public transport undertakings of the other member countries.

To sum up, the Association of the B.C.E. is open to all who are interested in the aims pursued and organises frequent symposia and meetings at European level, at which one may be sure of interchanging extensive technical information at all levels.

I would like the ECSC to give its patronage to the creation of the European Pilot Centre for the Treatment and Rehabilitation of Persons suffering from Brain Lesions at Hochfelden.

N. COOPER

The International Labour Organisation is often asked for advice on the advisability of initiating or expanding appropriate legislation aimed at introducing some kind of compulsory measure to secure employment for the disabled in open industry. I am not referring to the need for legislation for basic rehabilitation services and programmes - I feel sure we all agree such legislation is very necessary, indeed essential as a component part of social development policies. What I have in mind are special legislative measures or regulations providing for quota schemes (obliging employers to engage a certain quota or percentage of disabled persons), designation of certain jobs, allocation of priorities and preferences and compulsory notification of vacancies. As with most controversional subjects, there are very good reasons for and against the introduction of such compulsory measures and I thought the Symposium might be interested to know of the ILO's news on this subject:

It can be said that compulsory measures:

- provide evidence that the government supports in principle the employment of the disabled and encourage both the disabled and those working for them;
- provide a means of introducing employers to the idea of employing the disabled, and when selective placement techniques are used, employers become more inclined to accept them and soon recognise their worth as economic units;
- convince employers that all firms are being treated alike and that there is no unfair discrimination between for example, the public and the private sectors;
- provide employment for those disabled persons who might otherwise remain unemployed, because they lack the capacity to perform more arduous or more skilled work.

Conversely it might be said that:

- compulsion is wrong in principle;
- that disabled persons placed in this way might gain the impression that they are being placed on sufferance rather than merit;

- that only the more menial jobs are being reserved for the disabled;
- that the disabled themselves might feel that undue attention was being focussed on them.

It is up to each individual country, or group of countries, to decide wether the compulsory or voluntary method of placement should apply. However, if compulsory measures are adopted, the success of such measures is dependent on four main factors:

- a simple practical definition of a disabled person (as in ILO Recommendation 99);
- the existence of effective machinery for the registration of disabled persons;
- the existence of a specialised rehabilitation and employment service to assist employers in meeting their obligations;
- a system of inspection or enforcement to ensure that the employment obligations imposed are being met.

The Symposium will be interested to know that at the present time the ILO, in close collaboration with the United Nations and the World Health Organisation is undertaking a "questionnaire" enquiry of legislation, organisation and administration of rehabilitation programmes in 62 countries of the world, including most of the European countries. We shall be pleased to make the results of this enquiry (i.e., a comparative study) available not only to the Commission but to all concerned with the question of rehabilitation of disabled persons.

H. SYMANSKI

Ladies and Gentlemen,

All the papers that we have heard so far have shown evidence of a certain idealism, certain objectives and a great deal of optimism. However, in my capacity as medical inspector of labour in the Saar I am bound to damp your enthusiasm a little. I wish to play the part of Devil's advocate, that is, I hope that my comments will lead you to contradict me and point out what things are really like in practice.

I will take up the thread from Mr. MARON. Certainly the big firms comply with the legal provisions and employ the prescribed number of severely injured persons in their works, but out of 26 million persons gainfully employed in the Federal Republic only a quite small proportion are employed by the big firms, the majority working in medium-sized and small firms. But the firms and the employers are in the main concerned about their earnings and profits, and to a vast setor of the population and to many employers an injured person is not a fully competent worker, but more or less of a burden. In general, employers want only a labour force without handicaps, and healthy employees. This remains true even in these days of full employment, so that the placing of severely injured persons in employment encounters a host of difficulties.

The second aspect to which I wish to draw attention is that there is frequently reluctance to allow oneself to be rehabilitated. This tendency increases with age and with the severity of the effects of injury. Thus, many employees prefer benefits and care and dislike rehabilitation. In the Saar we have a saying: "He's doing well on public assistance". Let me quote one case in which I was concerned. A man of 57 with a healed tuberculosis, who was drawing 30% benefit, told me that despite twenty applications the Labour Exchange had failed to offer him acceptable work in dust-free enclosed rooms.

The conclusion to be drawn from this negative experience of practical conditions is, in my opinion, that work, and education on a broad basis of all concerned, are necessary in order to help the idea of rehabilitation to achieve a breakthrough, and that in practice this is impossible unless there is a statutory obligation to employ injured persons in industry, and that therefore these measures must be enforced by every legal means.

K. VAN ZUNDERT

I should like to ask wether you do not consider it desirable to study the possibility of including the social rehabilitation of disabled persons in Orders 3 and 4 of December 1958 of the European Economic Community on the social security of migrant workers.

In some member states there is in fact some discrimination in this matter against nationals of other countries.

E. de VERICOURT

The debates in which we have taken part are indicative of evolution in the matter of legislation from positive 19th century Malthusianism to the overall expansion that is necessary in the 20th century wherever economic conditions allow.

French legislation on occupational diseases, which was a step forward, is now out-of-date, and the tables which form part of it are the subject of litigation and of long-drawn-out official study. It is difficult to distinguish the compensation and rehabilitation of the chronic bronchitic from those of the silicotic, whose working conditions are often similar.

A further step forward is needed in order to find a general solution for the problem of incapacity, whatever its origin. Rehabilitation is just as important as compensation, which must not lead to undesirable inequalities. The future to which we look forward is full of hope for the disabled, in the setting of the studies made by the European Economic Community.

F. MONTES

Is there or is there not an obligation on firms to employ them? This is a debate without an end...

I believe that it is necessary to have legislation, because good will is not enough, and because it is necessary to avoid distortions which will have results unfavourable to those firms which show the most good will.

But such legislation must cease taking the cause as the criterion and bring into harmony accident legislation and disablement legislation.

However, the real problem is to instruct the employers and the wage-earners and make them sensitive. If consciences can be more easily touched, it will be easier to achieve a solution.

- Stress the adaptation of the job. Financial measures to promote this, but technical measures as well. Ergonomics. Gathering the results of practical experience at European level. (USSR: the blind).
- Placing in employment: special or general departments?
  - x General departments for gathering in and seeking offers of employment;
  - x Special departments for matching the offers to the disabled.
- Aim: to bring as many as possible of the disabled into what is termed the normal working environment - desegregation.
- Necessary harmonisation of the EEC laws in accordance with Articles 117 and 118 of the Treaty of Rome.

Here too what is needed is a tripartite approach by employers, wage-earners, including representatives of the disabled, and government representatives.

E. CRAVIOTTO

Prof. GERUNDINI dealt with this problem in an article in a specialist review. It is called "compensation psychosis".

Essentially it is a question of the possible tendency of the disabled person to believe that he is beyond recovery and to content himself with State aid, turning his back on reinstatement in productive activity.

But this tendency is already resisted by current legislation, which in practice treats the unlucky person as a culprit, in that the economic benefits that he receives are inferior to what he received when he was working.

Of course, the problem is not looked on as something to be dealt with by fiscal and repressive measures, but rather in terms of occupational retraining, whereby the subject can be reinstated in productive work.

One has also to bear in mind that legislation about the compulsory employment of the disabled may be quite notional in a country with full employment, but a "social fact" in countries where structural unemployment develops or persists.

We have not only to know the legislative enactments in different countries but also to achieve the harmonisation of these laws in order to try to remove the imbalances due to social and economic differences.

C. de GANCK

The comments made yesterday and today have shown clearly that immense efforts are being made in the scientific, technical, institutional and legal fields to bring about the full and complete integration of the disabled in the Community.

However, if one analyses these joint efforts, one finds that they appear to take as their starting point a certain ideal view of the disabled that has never been in tune with reality and never will be.

Indeed, it appears to be a basic assumption that all disabled persons without exception strive with might and main to reintegrate themselves in the community in general and work in particular.

However, in practice it is evident that this assumption, this ideal view, is a pretty utopian one and that broadly speaking we can distinguish three categories of disabled persons:

1. Those who take a positive view of rehabilitation and re-employment - undoubtedly the biggest group.
2. Those who remain passive and are indifferent to re-employment.
3. Those who are obviously recalcitrant and opposed to every attempt to capitalise on and put to some effective use their remaining economic potential.

I believe that this three-day symposium on the general problem of rehabilitation will miss its target if this aspect of the problem does not come up for discussion.

The passive attitude and the resistance to re-employment of some disabled persons is in truth a problem:

1. It is an economic problem because this passivity and resistance - whatever the reason for them - result in the dissipation of aid and money belonging to the Community which could have been used for other more useful purposes.
2. It is a psychological problem because the resistance of some disabled persons calls in question in the

eyes of the positively-oriented disabled, the efforts that most of the disabled are making to be reintegrated into working life.

3. But it is above all a problem for the disabled person himself, who thus severs his connections and throws away the chance he has of full reintegration into society and the full unfolding of his personality.

If the confirmation of the disabled person in his full equality with the able-bodied involves giving him every means and facility for holding his own in society independently and for exercising his unconditional right to work by converting it into actual re-employment, the community, his immediate circle and he himself will only regard him as a complete equal and accept him as such if he realises that he has the same social obligations as the community imposes on able-bodied persons.

The principal of these obligations seems to me to be that of being answerable for himself and for his own livelihood in the first instance, before he appeals to the community for aid.

This obligation is incumbent on the able-bodied beyond a shadow of a doubt, and in my opinion it can and should for the above reasons be imposed on the disabled.

It is at all events the only justification for measures aimed at putting the disabled to work.

It certainly seems to me that reasons given for putting the disabled to work, such as:

- it is good for their health
- the economy of the country requires it
- it is an essential condition for the development of his personality,

are in themselves insufficient justification for a policy aimed at the employment of the disabled combined with the maintenance of a check on their capacity for work, with the eventual aim of the withdrawal or reduction of aid - such is the practice in most countries - because these motives are questionable.

The only alternative is, in my opinion, to put the disabled and the able-bodied on a completely equal footing, not only as regards their rights but also as regards their obligations as members of the community.

This comment was unprepared, and is therefore lacking in finer shades of meaning and insufficiently thought out. It is probably open to dispute, but it seems to me that the very purpose of this symposium is to get a discussion going.

R. FRANCOIS

International League of the Associations for the Aid of the Mentally Handicapped

Declaration of the General and Special Rights of the Mentally Deficient

- Since the Universal Declaration of the Rights of Man adopted by the United Nations proclaims that every human being without any distinction whatsoever enjoys the general and inalienable rights of human dignity and liberty,

- Since the Declaration of the Rights of the Child adopted by the United Nations proclaims the rights of the physically, mentally or socially handicapped child to treatment, education and the care that his condition requires,

the International League of the Associations for the Aid of the Mentally Handicapped proclaims the General and Special Rights of the mentally deficient, as follows:

Article 1: The mentally deficient have the same fundamental rights as other citizens of the same age in the same country.

Article 2: The mentally deficient have the right to medical care and the physical treatment appropriate to the condition, to education, instruction, rehabilitation and advice which will enable them to develop their capacities and aptitudes to the maximum, however grave their handicap. No mentally deficient person may be deprived of this assistance on the grounds of its costs.

Article 3: The mentally deficient have the right to economic security and a decent standard of living. They have the right to perform productive work or to carry on any other useful occupation.

Article 4: The mentally deficient have the right to live with their families or with a household which is a substitute for it, to take part in all forms of community life and to engage in recreational activities appropriate to their condition. If it is necessary to place them in a special institution, the environment and the living conditions must approximate as closely as possible to those of normal life.

Article 5: The mentally deficient are entitled to the guardianship of qualified persons if this is essential to the protection of their persons and their possessions.

No person directly concerned with the treatment or housing of a mentally deficient person is to be allowed to act as guardian.

Article 6: The mentally deficient person must be protected against all exploitation, ill-usage or degrading treatment. If he becomes the object of legal proceedings, he is to be given the right of regular procedure which takes fully into account his degree of responsibility.

Article 7: Because of the seriousness of their handicap, certain mentally deficient persons are incapable of exercising all their rights effectively. In the case of certain others, it may be necessary to limit these rights or even to suppress them altogether. The procedure applied in pursuit of this limitation or suppression must legally safeguard the mentally deficient person against any kind of abuse. This procedure must be based on an evaluation by qualified experts of the social capacity of the mentally deficient person. The limitation or suppression of rights must come up for review periodically, and there must be a right of appeal to higher authority.

ABOVE ALL, THE MENTALLY DEFICIENT ARE ENTITLED TO RESPECT.

Note: This declaration was submitted to the United Nations Organisation on 24th October 1968. It was rejected by a number of countries which thought that they had other more urgent problems which they ought to solve first (in particular, the problems of malnutrition). Since then the Social Commission of the United Nations has adopted this declaration. It will be resubmitted to the Assembly of the United Nations Organisation next October.

PLACEMENT AND ADJUSTMENT IN A NORMAL FACTORY: PRACTICAL ASPECTS

Chairman: M. TROCLET
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REPORTS

G. DUBOT

1. Introduction

In the placement of disabled persons in and their adaptation to normal work, the employer must choose means in accordance with the aims to be achieved.

1.1. Aims

Once the aims have been laid down by the Management, it is important to establish and operate a relatively simple fast and efficient method suited to the scale of the firm.

On the practical level, we wish to report to you on our experience in a French undertaking, "LA REGIE NATIONALE DES USINES RENAULT".

1.2. Scale of the problem

The total labour force employed at all Renault establishments amounts to 94.000, of whom some 71.000 are manual workers, divided among a number of factories.

A recent study in a production division showed that 14% of the staff were disabled: 6% were slightly disabled and 8% more seriously so.

We therefore estimate that for the whole of Renault, about 11.000 persons require placement or special job adaptation.

1.3. Functions and duties

The functions and duties of the industrial doctor include facilitating the resettlement of disabled workers within the firm. Some jobs may already be suitable for certain disabled persons, whilst others will require modification, after a job study, to adapt them to the disabled subject.

A corollary of this is that the doctor requires a comprehensive knowledge of the different jobs. Such a knowledge can only be obtained by a job study followed by the compilation of a requirements card, which will subsequently be compared with the subject's physical capabilities card. Work of this kind demands close collaboration between a number of departments.

Both disabled and non-disabled staff can only be employed rationally on the basis of job studies.

2. Method used

2.1. Objects of job studies

The object of predominantly manual job studies is as follows:

1) Improvement of jobs, both on the technical level (efficiency, quality, costs) and on the human level (reduction of fatigue, elimination of accident risks, etc.).

2) Classification of jobs relative to each other, for job qualification.

3) Good matching of staff to the various jobs. This is labour selection and guidance.

2.2. General considerations relating to occupational selection and guidance

Occupational selection and guidance are based on two foundations:

1) the man and his abilities
2) the job and its requirements.

The practical guiding principle for selection and guidance is comparison of the capabilities and requirements cards.

2.2.1. Selection

Staff selection consists of finding the worker most suited to fill a given post; the point of departure is the job.

2.2.2. Guidance

Guidance comprises helping the subject towards an activity most suitable for his aptitudes and capacities as a whole : the point of departure is the man with his potential.

2.3. How a job study is performed

The method of study is the same for selection/guidance and for work qualification.

It is based on consultation of existing documents (schedules, instruction sheets) and on external observation of the occupation.

2.3.1. Job observation

The study is carried out after stabilisation of the job.

Observation is the main part of the work of the person carrying out the job study. It is of decisive importance for establishing:

1. the description of the work
2. the work requirements profile.

2.3.2. Analytical description of the work

A document is drawn up for each job studied. This includes the identification of the job, followed by information taken from the schedules.

The description of the work is analytic in form, with three headings:

- the operation in general,
- description of the operating cycle,
- special features.

These headings answer the standard questions: What, where, when, who and how?

This analysis clearly indicates:

- physical activity,
- mental activity,
- sensory activity,
- the working environment.

2.3.3. Determination of the job requirements profile

The requirements correspond to the minimum abilities necessary to perform the job.

They are divided into three groups:

1) Physiological requirements:

- Near vision
- Distance vision
- Hearing
- Possession of full upper limb faculties
- Working position
- Pedals or movements
- Robustness (effort)
- Resistance to effort
- Risks inherent in the job.

2) Factors giving rise to discomfort or nuisance:

- Vibrations
- Respiratory irritants
- Skin or caustic irritants
- Mineral oils and greases
- Toxic substances in general
- Climatic and temperature conditions

Length of working day.

3) Psychological aptitude requirements:

Rate of movements required
Dexterity
Co-ordination of movements
Concentrated attention
Dispersed attention
Comprehension

These requirements are estimated by means of the summary of job gradings.

Each criterion is examined individually and the job is finally classified in one of five categories.

When the job profile has been finalised, it is submitted to the medical service for signature.

3. Practical application of staff placement

Staff are placed in two stages:

3.1. Preselection

This consists of comparing the main requirements of the job with the corresponding capabilities of the worker to whom it is desired to allocate it.

This comparison is performed by means of the job group numbers.

Composition of group number

The group number consists of five figures:

The first 2 figures relate to certain physiological criteria.
The third figure concerns the type of psychological aptitude test.
The fourth and fifth figures cover nuisances or tolerances.

3.2. Individual selection

This comprises comparing the detailed requirements of the job with the capabilities of the worker it is proposed to allocate to it.

This comparison is effected by superimposing the requirements card on the capabilities card.

3.2.1. Requirements card

This card is a copy of the back of the job study card.

It is punched with the physiological and nuisance criteria.

It is circulated to departments after each job study.

The card is valid for as long as the job is not modified.

3.2.2. General capabilities card

This card, compiled by the medical service, follows the worker every time he changes jobs.

The doctor marks the degree of ability of the subject for each criterion in the appropriate box, grades to the right of this point being coloured red.

Comparison of these two documents, the requirements and capabilities cards, tells us wether the subject is suited to the job under consideration.

3.3. Statistical information

A punched card is produced for each job studied.

It carries punched information on qualification and selection.

Job lists compiled according to different criteria can be produced from this punched card index.

3.3.1. Job lists

These lists are drawn up at the request of departments or sub-departments.

The most common classifications are:

By study number by workshop
By group number by workshop
By group number by department
By wage grade by workshop

3.3.2. Mean indices

By calculation of the mean job requirements index, it is possible to establish a relative classification for each workshop and department.

A comparison of these indices with the "capabilities" indices indicates the staff utilisation possibilities in the relevant sectors.

4. Different forms of disablement and resettlement possibilities

It transpires that in our factory environment, our disabled workers almost all have purely medical handicaps, because with the improvement in safety, even if accidents are still too common, their consequences and sequelae are less serious, except, unfortunately, for accidents on the way to and from work.

However, there is one class of workers which is causing us more and more very difficult problems, and this is the old. These workers, worn out by a life of toil, can no longer perform normal or even light work in the production shop, much as they would like to do so.

It was in order to maintain employment for these persons that, in 1951, Renault set up a special workshop linked to a rehabilitation and work-retraining shop. In this workshop, old and disabled workers are able to continue working until retirement.

It would be wearisome to review all the classes of disablement with which we have had to cope; instead, on the basis of the criteria in our general capabilities cards, we should like to state some of the solutions we have been led to adopt for different forms of disablement.

4.1. Sensory handicaps

4.1.1. The blind and persons with impaired vision

4.1.1.1. Workers with one eye or whose visual acuity is very low (o.2 to o.3) for distance vision, this condition not being susceptible to improvement, are excluded from all jobs which obviously require good distance vision, and from all dangerous jobs (the operation of vehicles, trucks, travelling overhead cranes, presses and machines where there is a risk of projection of particles). Jobs with working positions at high level are also clearly unsuitable. However, such subjects can be re-employed on assembly work if their near vision is good. They can also do certain manual handling and workshop maintenance jobs. On the whole, this groups raises few problems.

4.1.1.2. Blind persons and workers whose visual acuity is very low, who are unable to work in the workshop because of the dangers of circulating and because, on account of their greatly restricted field of vision, they cannot come in the vicinity of overhead conveyors on account of downward projections, are employed on wholly tactile work in our rehabilitation workshop. They do jobs similar to those which they would otherwise perform in a normal workshop (tube bending, cutting to length, etc.) and are paid accordingly.

4.1.2. Persons with auditory handicaps, frequently suffering from occupational deafness

In some cases it was possible to employ this group in sound-proofed workshops, and we recently had occasion to note that a comparison of audiograms taken five years ago with recent ones taken after allocation to these sound-proofed workshops showed a regression of the occupational deafness. We also have anti-noise helmets, but these are very unpopular with the labour force. Noise is one of the problems to which there is at present a serious lack of rational solutions.

4.2. Persons with motor handicaps

4.2.1. Motor handicaps due to an accident at work, on the way to or from work, or other accident with serious sequelae affecting the upper or lower limbs. In general, workers who resume their work are practically re-educated; however, certain additional re-education is necessary to restore, if possible, or improve "the useful movement".

In the case of irreducible sequelae, such as anchylosis of a joint, it is always possible to find a half-seated, half-standing job for anchylosis of the knee, to eliminate a pedal in the case of tibio-tarsal anchylosis, to lower manual control levers in the case of anchylosis of the elbow or shoulder, et.c

Here are some typical recent cases for which solutions were found by job-adaptation:

> ....Mr. X, 30 years old, a welder by trade, using a welding torch: wound on the right forearm, affecting the median and cubital nerves. Severe sequelae with amyotrophia of the muscles of the thenar eminence, the hypothenar eminence and the interossei. A very co-operative subject. We completed the rehabilitation started in the town. After six months, this worker resumed his job and thus retained his trade; the modification of the working position consisted simply of increasing the diameter of the stem of the welding torch.
>
> ....Mr. T, 35 years of age, a former tuberculosis sufferer, and an alcoholic; returned to work. After

family troubles, he attempted suicide (by jumping under an underground train); both legs severed in the middle third. After being given prostheses and being re-educated to walk, was able to move about without a stick and could then be employed to drive a sweeper with manual controls only. No difficulties for three years, but following new worries and re-addiction to alcohol, he committed suicide.

.... Mr. V. Amputation of the bottom third of the left forearm. After fitting with a prosthesis, he was employed as a press supervisor and controller.

These three cases, in which the disabled persons concerned were very co-operative, show, if any demonstration were needed, that in re-education and resettlement, personal motivations play a preponderant part. Practically all our failures are due to an additional element of malingering, which we find most frequently in immigrant staff.

4.2.2. Persons with motor handicaps following an illness - either cardio-vascular (hemiplegics) or neurological affection

It is virtually impossible to employ these persons in a normal workshop. Furthermore, to enable us to resettle them, they would have to be sufficiently fit to come to work.

The few cases we have had have in general resumed work in our sheltered workshop, where it was possible for us to employ them thanks to modifications to the working positions carried out by the technicians of this workshop.

4.3. The mentally ill, alcoholics and persons with brain injuries

The mentally ill, alcoholics and persons with brain injuries suffering from subjective disorders, and epileptics, raise the most difficult problems. It is clearly impossible for us to employ in a factory subjects who would present any kind of risk when working with other people. Other persons in this group are resettled in jobs presenting the least possible danger, either on handling at ground level or as cloakroom attendants or cycle shed attendants.

4.4. Persons with tuberculosis of the lung

Persons with tuberculosis of the lung, who constitute the majority of our temporarily disabled staff, especially subjects from Black Africa, do not raise any problems. Although modern theories advocate a rapid return to work, we prefer to train these people for two to three months in the rehabilitation workshop before allowing them to resume full normal work in the ordinary workshop. We consider it dangerous to send patients straight from the sanatorium to the workshop with all the resulting constraints (shift-work, output). When they are resettled, we automatically exclude them from jobs with toxicity hazards (solvents, lead, foundry, etc.). Looking back over several years, we note that relapses are exceptional, except with alcoholics.

4.5. Heart patients

For heart patients, especially those who have suffered an infarction, resettlement is more difficult, and for this reason we often have to resort to occupational retraining, after a psychological aptitude test and a vocational training course. In this way we have been able to retrain a number of our workers, giving them more or less sedentary posts as checkers, filing clerks, storekeepers and metrologists.

A survey by all the doctors at Renault covering 115 cases showed that the incidence of the infarction was as follows:

52 times between ages 55 and 65
46 times between ages 45 and 55
17 times below age 45.

The classification by occupations was as follows:

28% executives

8% clerical workers
37% skilled workers
27% tradesmen.

So far as possible, we do not resettle these persons in work requiring quick sequences of movements, even if little physical effort is called for, and we also avoid noisy environments, since noise is a mental fatigue factor above 80 decibels. Other unsuitable jobs are in positions exposed to heat or to adverse weather conditions, jobs were there might be a safety risk (travelling overhead and other crane operators, vehicle and mobile equipment operators) and dangerous work (metal or timber structures, maintenance work at high levels).

Resettlement may thus appear very difficult, but in view of the age at which, as we have noted, the infarction tends to occur, i.e. in the majority of cases after the age of 50, it is possible for us to re-employ these subjects in our social workshop, which is, indeed, reserved for older staff.

In this workshop, where no individual output targets have to be reached, where the noise level is low, where work is performed on a bench, seated or standing at will, we can employ all staff for whom resettlement on the production floor would be impossible.

Furthermore, in many cases, the persons concerned hold partial invalidism certificates, which are converted, when they reach the age of 60, to "unfit for work" certificates.

4.6. Problems of old workers

The output of old workers is lower than that of young subjects. Many of their faculties deteriorate; on the other hand, however, their capacity for work remains, if not unaffected, at least high, sometimes until a very advanced age.

They exhibit more care, regularity, patience and even accuracy than younger workers, all of these being qualities which compensate for the fall-off in quantity in the form of higher quality.

These workers also endeavour to economise on materials, take better care of their tools and machines, and make for greater stability in the firm.

Suitable jobs are those of checkers, toolkeepers, light assembly workers and packers.

5. Future prospects for resettlement in full-scale production works

Over a period of years, most jobs have undergone a number of modifications, often tending in some way to improve working conditions:

Elimination of jobs requiring uncomfortable or acrobatic postures (a study on this point has been carried out by the Renault physiological laboratory).

Repositioning or elimination of pedals and replacement by manual controls.

Lowering or raising of working levels.

Modifications of lighting.

Sound-proofing of certain work-shops, etc.

5.1. Automation

Most jobs are now on a production or assembly line and are often automated. The workers employed on these jobs themselves say that whilst automation has eliminated certain physical constraints, especially manhandling, it has not brought about any reduction in overall fatigue. Indeed, more sustained attention and constant presence at the working position is necessary.

On some machines, before automation, the worker could work harder early in the day so as to have some free time at the end of the day; since automation this has been impossible, since the machine now controls the man and not the other way round. Hence, whilst less muscular effort is required, the continuous state of tension results in fatigue which is less easily banished by rest.

5.2. Problems through decentralisation

Looking back over more than 20 years of industrial medicine, we have to admit that as the years go by, the fewer "easy" jobs we have; this is because staff, with a few exceptions, have multiple skills and must therefore be capable of doing all the jobs in a particular category; the "easy" operations are the ones which tend to be decentralised or sub-contracted, so that it is becoming more and more difficult to find positions for persons with severe physical handicaps.

6. Conclusion

Recent statistics covering 100 cases show that after employment in a rehabilitation workshop:

47 persons resumed their former work

6 persons resumed the same job after adaptation

34 persons resumed work in another job with equivalent qualification

7 persons changed to jobs with a lower qualification because of chronic affections (generally alcoholism)

6 persons changed to jobs with a higher qualification, through acquisition of technical competence on training, after taking a psychological aptitude test.

6.1. The tally over 5 years (Billancourt Works)

Over a period of 5 years, in the Billancourt works, 420 persons followed a rehabilitation course and were resettled: the percentage were:

15% who had suffered injuries

56% former tuberculosis patients

13% heart sufferers, 50% of whom had had infarctions

16% persons with nervous or psychological disorders and alcoholics.

6.2. 16-year tally (Billancourt works)

From 1952 to 1968, we admitted 519 old people to our workshops, all of whom obtained a certificate of total unfitness to work at the age of 60.

1023 sick or injured people were resettled. Thus over 16 years, we endeavoured to deal as best we could with the cases of nearly 1600 workers.

The resumption of work after an illness or accident, retraining of faculties, adaptation of working positions and resettlement are possible only on the basis of teamwork with close collaborations between the following:

1) the various treatment bodies, doctors, hospitals, etc. it is often difficult to secure this collaboration between industrial doctors and hospital centres;
2) those responsible for placement in factories;
3) the administrators of work-rehabilitation workshops;
4) workshop administrators: heads of personnel departments, safety officers, workshop managers.

It is only on the basis of this close collaboration and the comprehension of all concerned that it is possible to get the maximum out of the facilities available to us in order to act in the best interests of the workers.

Dr. SALMON

The finding of employment for disabled persons when their rehabilitation is completed cannot always follow the ideal pattern of reintegration in their previous firm.

In many small or medium-sized businesses, the range of activities is too limited to allow changes in occupation and thus meet the needs of individual cases of rehabilitation. In any case, some disabled persons are away from work for so long that they no longer appear on staff registers; in other similar cases, the firm might have closed down or been converted with a consequent reduction in jobs. Finally, there are also disabled adolescents who have no previous occupational experience to help in their retraining.

In such cases, employment must necessarily be sought for such persons in a new firm and the procedure is more difficult. First, a firm must be found that can offer suitable working conditions for a disabled person, then this person must be given a start and it must be made certain that he can hold the job.

All this is generally the responsibility of the employment departments, which should have a special office for disabled persons. The social services of other social security organisations may also be involved, as may careers guidance centres or vocational training establishments, the latter when a new qualification is required for rehabilitation.

All these organisations may work according to systems peculiar to their own regulations or to those in their respective country, but from the practical aspect the procedures hardly vary. These various aspects will now be described, dividing them into three main stages:

the preliminary steps
finding employment
supervision of employment.

I. - Preliminary procedures

Finding available jobs

The finding of employment must be preceded by a series of preliminary steps, amongst which the finding of available jobs is one of the most important.

The government employment departments are obviously well placed to do this kind of work because of their information system which should receive all information on situations vacant from the outside. They are also usually in touch with the regional developments groups and are therefore kept informed of any new openings.

However, a large number of disabled persons first go to a vocational retraining centre. These establishments approach the regional employment exchanges to find jobs for their trainees but they may also tackle this task themselves, in which case they have to search for jobs.

Their searches cannot be limited merely to noting situations vacant appearing in the newspapers. It is to their interest to prepare a list of local firms likely to offer jobs in the range of occupations for which training is given, and to visit these firms to check the existing possibilities for themselves. These visits initiate a policy of relations with the firms which, as our experience has shown, is extremely useful for vocational training centre. On the same lines, careful records are kept of firms that have previously taken on trainees. Often requests are received from these employers when they have been satisfied with the vocational abilities of former trainees from the centre.

Whatever prospecting methods are used, they should preferably not extend too far from the individual's local background, as otherwise additional problems of uprooting may arise.

Preliminary contacts

Where employment possibilities exist, contact must be made with the firm to further these possibilities. The establishment of relations at this time between the person responsible for finding a job for the disabled person and the prospective employer or his representative is a delicate stage on which the success of the subsequent placing primarily depends.

The person responsible for finding employment must appear to the employer to be a valid spokesman who is aware of his needs and consequently able to propose a suitable applicant. He must not give the impression of coming to beg favours, but rather of a person able to offer assistance.

For his part, the employer must show understanding for the disabled person or his representative, but this attitude is far from widespread as many prejudices still exist. Some factors can fortunately have a favourable effect; these include the more or less acute need the employer has for skilled labour, successful experience he may have had with disabled persons in the past and finally the high opinion he has of the training given in the vocational retraining centre. Because of this last aspect, many centres try to include employers on their board of directors or panel of examiners.

These preliminary steps should therefore be taken in an atmosphere of mutual understanding and should lead to an objective assessment of the realities by both sides.

Study of the employer's requirements

The interview with the employer must clarify not only his precise manpower needs but also his requirements. The higher the qualifications required for the jobs to be filled, the greater these requirements will be. It is therefore useful to know the qualification criteria generally taken as a basis by employers. A fairly sharp distinction emerges between private and public enterprises.

In the private sector, a paper qualification (diploma, certificates of vocational skills and other certificates, etc.) is of little importance for small firms; in the larger concerns, it is often no more than an introduction, a sort of "visiting card". Practical vocational knowledge is the determining factor in the small firms where a practical test is essential before anyone is taken on. The same applies to the large firms, although they first require occupational selection tests: it is useful at this point to supply information obtained from similar tests made in the employment department or vocational training centre.

In the public sector, on the other hand, the possession of a paper qualification appears essential and this can be to the disadvantage of an adult or adolescent disabled person who has not previously received any vocational training in his conventional education. In some Community countries, no such qualification is as yet granted on completion of retraining courses for adults, wether or not disabled. This leads to a much more general problem, that of permanent instruction and refresher training for adults, which is beyond the scope of our subject. Nevertheless, the absence of a qualification is still all too often an insurmountable obstacle to the finding of jobs for disabled persons in the public sector, whereas in fact the usually less arduous work rate in this sector should facilitate their placing in employment there.

In the public service, the administrative insistence on formalities operates against disabled persons, whereas in the private sector, once the initial prejudice is overcome, a comprehensive, human and flexible attitude is encountered more often than one would imagine.

Other requirements may be imposed.

Age may be an obstacle, but this is a general problem, although more acute for the disabled. The question of physical strength will be considered later.

Mention should also be made of the general attitudes adopted by employers resolutely opposed to taking on disabled persons, as are sometimes found in firms that have recently been modernised or set up with the assistance of public funds, which should be forced by the Government to adopt a more positive attitude. On the other hand, the understanding attitude shown by other employers who ignore the disability, provided the applicant has the necessary vocational skills, is often surprising.

Finally, the influence of cyclical economic factors should be stressed: a high level of economic activity with a scarcity of available manpower often causes employers to relax their requirements and abandon their prejudices.

Study of the proposed occupation

Once there is a prospect of employment, it is necessary to make certain that the job will be suited to the general skills of the disabled person.

This requires a job study from both the physical and occupational aspects.

With the disabled, it is essential for the job requirements to be compatible with the individual's physical qualities. This obligation necessitates:

a) precise assessment of the residual work capacity of the individual, and
b) an estimate of the expenditure of energy and the particular stresses to which he will be subjected in his new job.

The paper by Messrs. MIROT and DUBOT has shown the existing possibilities of industrial medicine in this field thanks to the development of functional evaluation techniques and ergometrics. However, it must be realised that although such studies can perfectly well be carried out in large firms having a well-equipped medical department, this is often less possible in medium-sized and smaller firms not having the same facilities. In the latter case, the individual's physical aptitude for work will have been determined in a functional evaluation unit outside the firm, prior to his engagement or during his occupational retraining. Such units are unfortunately still too scarce to make this method more widespread.

The assessment of the energy expended in a job has also benefited from the progress made in medical investigation techniques. A large number of occupations has been studied and energy norms established, but as we pointed out in a personal survey such assessments may be difficult for jobs where working conditions are extremely variable. Alongside assembly lines and stationary jobs on machine tools where the occupational movements are regularly repeated, there are many jobs where the operations vary continually throughout the day. For this type of job, which is more frequent in smaller firms, an individual job analysis would have to be made each time, something that is just conceivable in the context of experimental research but is difficult in the working environment.

Finally, when the applicant's physical fitness has been defined outside the firm, the problem is to match it with the requirements of the job.

The ideal system would be co-operation between the rehabilitation doctor and the company doctor, but such contacts are not always easy in practice. In many cases, the person responsible for job prospecting will merely have a card listing the medical contra-indications and will only be capable of a very approximate approach to the physical working conditions in the proposed job.

A similar analogy can be drawn between the occupational skills of the applicant and the knowledge required for the proposed job. Here the careers officer's role is a vital one and requires him to have a thorough knowledge of careers. In fact, his duty is to act as an intermediary between the supervisory staff of the firm and the person responsible for assessing the occupational knowledge of the disabled person. However, the assessment of the occupational skills of the applicant will often be very superficial if he has not attended a vocational retraining centre. If he has, the employment officer may profitably ascertain the opinions of the instructor or teacher in order to have more precise information.

II.- Placing in employment

Introduction of the person seeking employment

Once the preliminary steps have confirmed the possibility of a job for a disabled person, then comes the stage of arranging his employment.

The first operation is to introduce the applicant to the employer.

There are various ways of doing this:

a) The employment department that made the preliminary enquiry can introduce him to the employer. Sometimes the social service of another social security organisation does this.

b) If he comes from a vocational training centre, the centre staff often act on his behalf: the employment officer, if there is one, or otherwise the social assistant, the instructors and teachers or the management.

c) Finally, the person seeking employment may approach the firm on his own, on the basis of information he has obtained.

Reviewing all the cases that have left our training centre in recent years, we can make the following comments:

a) The efficiency of the government employment departments varies considerably and this has a great effect on the results. The presence of staff specialising in the disabled in these departments is becoming increasingly necessary in our countries, in view of the special nature of this type of operation.

b) Surveys made amongst our former trainers show that they are still too often left to their own devices and they rightly complain about this. They consider the actions of the employment officers to be too bureaucratic.

c) Our experience has also shown the effectiveness of approaches by the staff responsible for vocational retraining. It has been found that our instructors are the best employment officers because as they are "in the trade" they can make contact more easily with their colleagues in the factory and gain their confidence. As they are well acquainted with their former students, they can uphold their interests with a maximum of information.

In fact, the greatest successes in finding employment that we have encountered resulted from a combination of these approaches. A certain amount of individual effort is essential initially, as it shows that the disabled person really wants to find employment.

The operations rely mainly on the organisation and efficiency of the government employment departments, but where there has been prior vocational retraining, action by the instructor staff greatly facilitates the approaches.

Aptitude tests

After being introduced, the applicant has a difficult obstacle to surmount, the aptitude tests.

From the occupational aspect, they will be necessary mainly when a qualification is required. They may amount to no more than the production of written proof of qualification (diploma, certificate, reference, etc.) or material proof (workpieces made previously, designs, book-keeping work, typing, etc.). More often, the applicant has to make a test piece or take an examination in the case of a higly skilled occupation.

Some employers require a probationary period, at their expense or that of the employment department. This may lead to articles of apprenticeship if the disabled person does not have the required qualification for the proposed job.

The large companies frequently make use of psycho-engineering tests.

Entrance examinations covering both general and practical subjects are customary in public or similar organisations.

At the same time, the applicant must undergo medical examinations. It is here that the above-mentioned co-operation between the vocational guidance or rehabilitation doctor and the company doctor responsible for the examination is most beneficial.

The real problem is to reassure the company doctor who does not know the disabled person and must accept responsibility for engaging him. His misgivings will often be overcome if he receives a detailed history giving him reassurances on all the important points. Such reassurances can obviously be given quite easily if the applicant comes from a vocational training centre where his suitability for the new job has been thoroughly and efficiently checked over a long period.

In fact, the lack of understanding shown by many of our colleagues in industry is due rather to a lack of information and a reluctance to accept the responsibilities than to any real prejudice. The role of the rehabilitation doctor is therefore to give information and to certify the physical suitability of the applicant, in order to cover the responsibility of the company doctor.

Another aspect that makes a practical difference is wether the disability is visible externally or unnoticeable.

A Dutch survey made last year showed that the proportion of blind, dumb and paraplegic persons re-employed was low (less than 10% of the total disabled), while on the other hand cardiac cases, physiologically handicapped persons and mild cases of locomotor disorders found employment more easily (more than 40%).

Another difficulty is the legal obligation in some countries for the new employer to bear the load of the previous disability in the event of a new accident aggravating the existing disability. Such provisions are obviously not calculated to facilitate the re-employment of the disabled and should be revised or amended as soon as possible.

Practical problems raised by engagement

The main one is probably the assessment of pay. Our personal experience shows that persons newly engaged generally start with the basic wage for that occupation. We do not consider that they should start at a lower rate because they are disabled. Collective agreements should not normally permit this.

However, increases are possible at the start when the employment departments assist in the wage costs.

Other increases will follow at the end of the probationary period or later, depending on how well the employer is satisfied. However, despite these increases, the disabled worker is unlikely ever to reach the level of wages of a normal worker of the same age; the differential may well continue, to his disadvantage.

This differential in wages is a subject of concern to the trade union organisations as they do not accept it and therefore sometimes give the impression of inhibiting the employment of disabled persons in factories.

The acquisition of tools and work clothing is a purely financial problem.

The question of daily travel to and from work may be more difficult. It is obviously better for the journey to be as short as possible to avoid excessive fatigue. The means of transport should be convenient with as few changes and connections as possible. The use of a private car often facilitates such travel; sometimes the vehicle has to be adapted for the disabled person. If the journeys are too long or tiring it becomes essential to move house. Consequently, a resumption of work may be accompanied by considerable expenses, for which some financial assistance should be provided. In some cases, the work place in the new company has to be fitted up or modified to adapt it to the disability. These questions have already been discussed in the paper by Messrs. MIROT and DUBOT and the methods of application differ little for the subject with which we are concerned here. Usually, it is a matter of improving the working position and facilitating the method of working by modifying the positioning of the parts to be machined, adapting the controls and simplifying the arrangements for the feed,inspection and removal of the parts.

Such changes, which difficult to arrange in a firm where the disabled worker is already employed, become even more difficult in the case of a new firm. Despite the regulations on the subject, it appears that these modifications to the workplace are fairly rare and generally only amount to minor modifications to the tooling.

Administrative steps

Other steps of an administrative nature must be taken and here again the assistance of the employment officer is required.

The resumption of work may necessitate the renewal of a work permit for foreigners, who often forget about this formality. It is advantageous, if not obligatory, for the working conditions and remuneration to be set out in writing, and the employment officer will check the wording of the documents in the interests of the newly engaged person.

More specific documents have to be drafted when the employment departments agree to pay part of the wages during the initial period. Here the employment officer needs to show a great tact in his approaches. Some employers are not at all interested in these measures, advantageous though they be, and provided the applicant appears suitable they will decline such arrangements, probably fearing an official interfering in their department. Others show a paradoxical reaction to these measures: they suspect a poorer work performance from the disabled worker introduced to them. Finally, yet others show too much interest, a tendency to exploit cheap labour. It is therefore up to the employment officer to adapt his attitude according to the employer's reactions.

III. - Supervision of employment

Probationary period

Even when an employer has agreed in general terms to take on a disabled person, the process is far from complete. The new worker then embarks on another difficult phase as he is generally only taken on for a trial period and final engagement depends on how well he can adapt to his job. It is therefore important to follow his progress during this interim period, to ensure that he adapts correctly to the working conditions offered.

His adaptation must first be checked from the physical angle. It is up to the company's medical department to ensure that the work place is suited to the physical abilities of the disabled person and to the medical contra-indications specified in the preliminary approaches. The problem of resistance to exertion is particularly important and in this respect disabled persons who have attended a vocational retraining centre before employment have a clear advantage over those who are recruited direct.

In a recent study made by one of our staff on the employment of a group of injured persons leaving our centre, it appears that the majority of them were satisfied with the training to withstand exertion they were given at our centre and said that they experienced no difficulty in adapting to their new work. Some were even astonished at their physical fitness compared to that of young adolescents fresh from technical college where they have less intensive occupational practice.

Adaptation to the occupational tasks is the other criterion for success in finding the right employment. A distinction must also be drawn between disabled persons who have benefited from prior vocational training and those placed direct in a firm. The former have an advantage provided the training received does in fact correspond to the actual tasks they are performing in their job. Disabled persons who have received vocational retraining appear to their employers to be workers immediately able to pull their weight and fit into the firm more easily. Contacts we have maintained with former trainees confirm this. Some of the persons questioned were also pleased that they had received a fairly broad and versatile training which increased their ability to compete with other workers and enabled them to gain promotion rapidly, while others regretted that their training had been too general and had not given them the detailed knowledge required for a very specialised job, which shows how difficult it is to organise training programmes because of the diversification and constant development of industrial techniques. For persons employed direct, reintegration into working life may be more difficult because it is more sudden, and the success of the operation largely depends on how they are treated by the supervisory staff.

Adaptation to the new job may also raise problems of a psychological nature. To the disabled person, starting work is a vital stage that obliges him to break away from the state of social dependence in which he has been living for some time and to move on to the stage of occupational independence, the ultimate aim of rehabilitation.

In view of the emotional "fragility" of many of our disabled, it is easy to see that this change can cause numerous difficulties and can engender confusing attitudes even going as far as a genuine escape reaction.

These considerations show the importance of the way disabled persons are received in the firm; the medical department, technical supervisors and social workers all participate in this reception, and the employment officer may also be associated with it, as he has acquired so much knowledge of the disabled person and gained his confidence. At this stage, there should be perfect liaison between the employment departments and the employers.

The probationary period is obviously not always successful and in some cases is not extended by the employer. The employment department then has to take on the disabled worker again and start new approaches to another firm.

Quite frequently, applicants take on a number of jobs before settling down with one employer. The reasons for this attitude include dissatisfaction with working conditions, the level of wages paid or the length of the journey to work; these are not always justified and have to be restrained.

We consider that temporary employment in a job that is not completely suitable is preferable to unemployment, and the important thing is to get a job so that useful references will be available later.

Generally speaking, it is recommended that the period between the end of vocational retraining and finding employment should be as short as possible, as otherwise the effects of training to withstand exertion will be jeopardised, the occupational knowledge acquired will be gradually lost and the return to a state of dependence will be encouraged.

Permanent employment stage

The permanent employment of the disabled person does not necessarily put an end to the operations.

Contact should be maintained periodically with him to ensure that he is fitting in well in his new job and that as a result of his rehabilitation he is really settling down as desired in his new job.

Contacts are also essential for rehabilitation experts to enable them to draw up a long term balance sheet of their activities and to confirm or modify their working techniques.

Such studies are unfortunately far from easy to carry out. Enquiries by post are often fruitless; many retrained persons never reply. Then they have to be looked up individually at their place of work, but as they are generally widely scattered these searches are long and laborious.

Often too, insufficient time has elapsed to give a general picture. Consequently we shall limit ourselves to a few salient facts based on our personal experience. The settling down of the disabled person in his new occupational life depends on both personal and external factors. Individually, the character of the person will essentially determine his future, the stability of his behaviour will ensure his stability at work and behavioural disorders will often affect his progress in his job.

Of the external factors, economic trends and movements on the labour market are the most important: most observers have to admit that a falling off in employment almost always has greater repercussions on disabled workers.

Other factors can also affect progress at work: initiative, a desire for promotion, the material needs of the persons concerned and in a different context the industrial changes or relocations in the regional environment.

Absenteeism is another interesting factor to analyse: several surveys show a lower rate of absenteeism among disabled workers such as cardiac cases, while those suffering from chronic diseases liable to periodic aggravation such as bronchial dissorders or lumbago are more prone to absenteeism.

Another subject for study: the trend in earnings. In this respect, it appears quite clear that those having benefited from vocational retraining have an advantage and our experience indicates that the phenomenon of paradoxical luck is not very exceptional; on the other hand, direct placings appear to be confined more to lower-level jobs and modest wages.

All these considerations show the complexity of the tasks involved in finding employment for disabled persons in a normal environment. The operation appears to us to have to reconcile two worlds:

a) that of the disabled person who has been cut off from working life for some time or who has never worked, and who has in addition a reduced capacity for work, and

b) that of the employer, who is primarily concerned with problems of production and output.

Its success will largely depend on how well the parties concerned are informed, on economic factors and regional job prospects, on the scope of the incentives and above all on the competence and energy of the persons responsible for the operation.

This means that if an efficient policy for the rehabilitation of disabled persons implies the existence of a well-structured and well-documented employment system, it is also necessary to ensure that those organising it have the training and human qualities required for their mission.

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DISCUSSION

L. SADO

In the Paris region a working group within the framework of the Consultative Commission on the Employment and Resettlement of Handicapped Workers has studied a system similar to that discussed by Mr. DUBOT for bridging the gap between the supply of and demand for employment so as to ensure that the jobs offered correspond to the abilities of the persons to be placed, thus avoiding failures.

The means adopted is a slip with information on the vacancy, which is to be compared with the aptitude slip completed by the resettlement departments for handicapped workers at the time of placement.

This slip is made out in terms of job requirements and therefore does not duplicate the aptitude slip.

On the practical plane an experiment has been carried out in one of the "départements" in the Paris region, with the consent of the Labour Directorate of the département, the cooperation of the head of the employment agency of the département, and the assistance of a placement investigator who specialises in the resettlement of disabled persons. This placement investigator is at present contacting various employers in the département. Generally speaking, the heads of companies have given favourable reception to this system.

Obviously the possibility of taking in disabled persons depends on the opportunities offered by the jobs for the various types of disability, and the slip which is being studied will be particularly useful to firms with a variety of jobs to offer. Thus it is sufficiently large firms that the placement investigator contacts in the first instance.

If the experiment gives conclusive results it could be generalised, and the working group is studying how the information given by the heads of companies can be processed by the trade organisations in order to prepare for the visit by the placement investigators.

A. MARINELLO

The experience gained in Italy shows that the problem of the placement of disabled persons can, as a rule, only be solved by compulsory appointment enforced by law.

This assertion applies both to workers who return to the firm where the accident occurred and to those who change their place of work, and it is also valid in the case where the disabled person has followed one or more courses of vocational rehabilitation, since in general the employing classes are somewhat prejudiced against employing disabled workers.

However, in Italy, with the entry into force of the 1968 law, even placement enforced by law has undergone a marked and disquieting decline, to such an extent as to reduce substantially the opportunities for employment of disabled persons, with the result that, primarily through the efforts of ANMIL, which I represent, a large-scale campaign has been started in the country, aimed at the Government, with a view to obtaining from it a thorough revision and improvement of these arrangements.

In the meantime, only very few disabled persons are finding employment through the above-mentioned Law 482, thousands are now unemployed, and over 250.000 jobs are unfilled owing to the ineffectiveness and shortcomings of that law.

The phenomenon of unemployment of disabled persons is even more dramatic if we bear in mind that the bodies failing to fulfil the obligation to employ disabled persons include the State and the public authorities in general. A partial survey made by us on the basis of reports submitted shows that:

(i) in a State establishment of 72.000 employees, 879 disabled persons have found jobs and 1.220 jobs are still vacant;

(ii) in a personal establishment consisting of employees of various public bodies other than the State, totalling 74.000 units, 693 disabled persons have found jobs, and 1.591 jobs still remain vacant.

It is quite obvious from this that in Italy both private employers and public bodies are calmly breaking the law of 1968 which, as we have already said, has resulted in great setbacks for the special categories with regard to compulsory placement.

The aim which we set ourselves with the revision of the law is that of giving effect to the right of the disabled person, whatever his category, who has lost his job owing to accidental events, to compulsory employment by private firms and by public administrations. There is nothing more painful than to have to say that a disabled person who has paid, by the loss of part of himself, such a large and perhaps excessive tribute to progress, must remain without employment owing to the inertia or default of society. The bitterness is even greater if, despite the substantial financial resources employed in order to enable disabled persons to be taken into vocational rehabilitation courses, which should make possible automatic resettlement in a job, the disabled person is not employed on the basis of the working abilities which he has reacquired.

R. SMEYERS

We wish to draw your attention to the problems, possibilities and importance of reintegration, rehabilitation and employment of persons

1) with disorders of the limbic system, neuro-vegetative disorders, so-called instrumental dysfunctions, constitutional or acquired;
2) with disorders in the affective and emotional sphere, and in the psychological sphere;
3) with disorders in the intellectual functions: intellectual abilities and the speech-volition system.

The problems arise not only in the case of permanent dysfunctions but also in cases of temporary regression or inaction of certain psychic dynamic mechanisms. In the motivation and determination of aptitude for resettlement in the case of somatically handicapped persons the deep-lying psychological factors and the psycho-social factors are very important and perhaps paramount.

H.J. SOEDE

The thing that struck me in listening to yesterday's papers was that the speakers concerned themselves almost entirely with the disabled persons themselves and hardly at all with their jobs. In this afternoon's paper this was revealed in another way. I have a feeling that the failure of resettlement is often the fault of the job. I should like to put forward the following idea.

For healthy people very extensive studies are made concerning their jobs, their tools, and the potentialities of the person both from the physical and from the mental point of view. It would be a good thing if a similar approach were made exclusively for disabled persons; that is, the most fundamental possible adaptation of the job to the human being, so as to make the latter's performance as good as possible without his suffering any adverse effects.

Such an approach provides a new viewpoint from which to regard the mental burden borne by disabled persons. A disabled person has to bear a greater mental burden than a healthy person. The reasons for this are as follows:

1. The job has not always been specifically designed for him and the disabled person must therefore perform more operation, and more cumbersome ones, in order to perform the same task.
2. The wearing of an artificial limb or part will call for much more conscious information-processing, especially in the apprenticeship phase. And it will therefore also impose a greater mental burden on its wearer.
3. Present-day artificial limbs contain few if any feedback paths. The disabled person must therefore make use of paths other than the normal ones. An alternative feedback path is, for instance, often the visual feedback path. This method for feedback imposes a greater mental burden by involving higher central mechanisms in the nervous system.

There is therefore a greater mental burden for the disabled person in the performance of motor or partly motor tasks. On the other hand there is also a reduced ability to bear burdens in many cases; the information-processing capacity can sometimes be reduced by, for instance, a shock when an accident occurs, or increased emotionality or preoccupation, being beset by all kinds of problems which the healthy person does not have. What was said this afternoon about tempos imposed by machines is easy to understand in terms of mental burden. The conclusion that I now wish to draw is that above all the disabled person runs a risk of being mentally overburdened. In order to prevent this we must take action with regard to the jobs which the disabled person is given to do. And in my opinion we here have problems which are not unknown to an experienced expert ergonomist. He will be able to say what parts of a job impose a heavy mental burden on a disabled person. I wish to present this as a suggestion to those who have leading positions in rehabilitation.

PLACEMENT AND ADJUSTMENT IN PROTECTED WORKING CONDITIONS : PRACTICAL ASPECTS

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REPORTS

Dr. HEERING

1. What is "sheltered"?

1.1. Discussion of the term "sheltered"

It is open to discussion wether the term "sheltered" is correctly used in connection with "work", "environment" or "conditions". On the one hand it may be said that nowadays practically every type of work has a more or less sheltered character. It is not for nothing that we have our laws for the protection of safety and health at work. In addition, we offer workers "shelter" through our social security provisions. Our entire generation is better protected against actual industrial hazards and the risks of finding oneself unable to work than were our grandparents, since almost a century of social legislation has radically transformed the situation of the wage-earner. Indeed, some fear that the pendulum has swung too far: that people are now overprotected and are as a result becoming soft and easy-going.

I do not wish to enter into this controversy, since many reams of paper have already been filled by it. Instead, it is my intention to draw your attention to a more important reason to object to the term "sheltered". It is that it suggests that the people concerned are being carefully wrapped in cotton-wool, in other words that one is only trying to spare them and make things as easy as possible for them in all respects. This is most certainly not the case. The question therefore arises of what we do in fact mean by "sheltered employment" in the specific sense. The term is generally used in connection with the disabled. It then obviously indicates additional or extra shelter enjoyed by the disabled at work. This addition is obtained by certain adaptations - not to the disabled person, as in the title of this paper - but to the normal working situation. For this reason, in my country, we often speak of "adapted employment facilities". The purpose of these adaptations is plainly not of an economic but of a social nature. Hence the term "social employment" ("sociale werkvoorziening"), to be found in the name of our Social Employment Law (Wet Sociale Werkvoorziening).

1.2. Type of adaptations

The adaptations to the labour situation for the disabled relate mainly to two factors:

1. the immediate working conditions
2. the financial structure of the labour organisation.

1.2.1. The immediate working conditions

In 1959 and 1964 international seminars were held on the subject of sheltered employment, in The Hague and Saltsjöbaden (near Stockholm) respectively. The third conclusion of the 1964 seminar mentions, in this connection, working facilities "supplied under conditions specially designed to meet the temporary or permanent needs of handicapped people".

All kinds of arrangements may fall within the scope of this description: the removal of steps, modification of a machine, more attention paid by the management to employees, regular medical examinations, etc., etc. Although this hardly counts as a particular facility for the disabled - being widely used in ordinary factories - we should mention the pneumatic and electrical transmission of energy, which is a help to numerous disabled persons and in many cases constitutes the condition which makes it possible for them to work at all.

1.2.2. The financial structure of the labour organisation. Under the capitalist system, most work takes place in a firm, i.e. an organisation which must earn sufficient from its products or services that after allowing for expenses a profit remains. In communist countries the making of private profit is impossible, but even there it is important to ensure that costs do not continuously exceed income. Whenever state subsidies are granted, in either a capitalist or a communist country, to industries or industrial sectors, it is a sign that the equilibrium between earnings and outgoings has broken down. Subsidies are granted to prevent a particular industry or firm from collapsing, or to give them a chance to develop, against the threat of competition. In the field of sheltered labour, the state usually makes a contribution in order to maintain the balance between expenditure and income. However, the aim in this case is different: it is to provide compensation for the loss of performance of the disabled and also for the extra costs entailed in the special adaptations of the working situation (see 1.2.1). Without this subsidy it would often be necessary either to pay the disabled employees a much lower wage or to close down the facilities because of excessive financial losses.

2. Aims and functions of social employment in modern society

2.1. Aims

2.1.1. The most important aim of social employment is indisputably the provision of opportunities to work. The persons concerned are obliged, owing to serious physical or mental deficiences or disorders, to cease to exercise their occupation independently or are not accepted as employees by ordinary employers. Although not all employees are required to achieve an equally high output in industry and also in other fields of employment, there is nevertheless always a limit which fixes the permissible minimum. For persons who have definitely become incapable of working in a normal occupation, social employment offers an opportunity to participate in industrial life nevertheless.

2.1.2. In addition social employment has the aim - or at least it ought in my opinion to have the aim - of giving the persons concerned a chance to develop or redevelop their working potential. A person who wishes to go back to work after a serious accident or illness, but is unable to continue in his old job, must normally practise intensively in order to be able to perform even the simplest working operations. Furthermore, he will quickly become tired and will experience difficulty in re-accustoming himself to life in the community; in brief, in many cases, a thoroughgoing process of adaptation will be required. For such persons social employment will provide an opportunity not only of working but also of increasing their working capacity back to the highest possible level in and through the work they perform. It may perhaps be objected that in practice it is very seldom that a disabled person succeeds in returning to the normal labour market by way of social employment. This is true, but first of all there remains much that we can do to increase the possibilities, and secondly it is important even within social employment, as regards both the production of the persons concerned and their working satisfaction, that everyone's working capacities are developed as far as possible. A workshop where everybody does more or less the same simple and monotonous work does not meet the requirements for good social employment.

2.2. Other functions of social employment

Although the above aims also indicate the most important functions of social employment in our society, other functions can be distinguished as well. Let me briefly refer to some of these:

2.2.1. Its significance for social security, especially sickness and invalidity insurance, is considerable. The founder of modern social security, William Beveridge, wrote that "income security which is all that can be given by social insurance is so inadequate a provision for human happiness that to put it forward by itself as a sole or principal measure of reconstruction hardly seems worth doing".1)

In other words, a welfare payment is a miserable compensation for the loss of the opportunity to work. For this reason sickness and disablement insurance in particular must always be combined with rehabilitation with the object of getting the disabled person back to work again. Without attempts at rehabilitation, a sickness or invalidity payment can easily become a reward for passivity. Now social employment can, provided that it is operated correctly, constitute an important means of rehabilitation.

2.2.2. What is the significance of social employment for the health of those concerned?

So far as I know, there has been very little research, if any, on this point. Practical experience, however, provides many indications in support of the assumption that in general the state of health of disabled persons is favourably affected by their placement in social employment.

2.2.3. The reason for this is not clear, but there is justification for the view that this favourable influence is connected with the psychological boost given to the person

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1) Sir William Beveridge, Social insurance and allied services, par. 440.

concerned by his re-integration in society and liberation from the oppressive feeling of uselessness. He is participating again, has regained his place, again has responsibility, and again earns all or a large proportion of his living. His social status rises, and with it his self-confidence and self-respect. This effect on the well-being of the disabled is most certainly one of the most important functions of social employment.

2.2.4. This also eliminates one of the causes of tensions and conflicts in the family and of social decline. In many countries invalidism results in social rejection, not only of the invalid, who becomes an outcast, but also of his family. The beggars on the public road are only one symptom of this. In most cases social employment can stem this process by keeping those concerned more or less on their own social level.

3. Responsibility for the organisation

3.1. The right to work

The moral right of every individual to work is enshrined in the conscience of the world and is expressed in Article 23 of the Universal Declaration of the Rights of Man. This also applies to the disabled person who still wishes and is able to work, although his working ability is substantially reduced. The objection that Article 23 does not explicitly mention the disabled is not valid, since it does not mention any other categories either: the Article simply mentions "everyone".

3.2. The responsibility of the State, lower-level government bodies and private organisations

If this moral right is to be translated into reality, the State must be involved. The organisation of social employment is still considered much too frequently to be the exclusive responsibility of private initiative; indeed, it is often regarded as a matter of charity. Against this, Conclusion 6 of the seminar held in Sweden in 1964, mentioned above, states that "the primary responsibility for sheltered employment rests with the State which should recognise that it has an obligation to see that sheltered employment is available for all those who need it". This does not exclude the participation of private organisations. I take the view that this participation, provided that it is afforded in the correct spirit and with due expertise, should be accepted with gratitude. But the State must ensure that there are sufficient adapted working facilities for the disabled and may therefore itself have to organise these facilities. However, it can also put lower-level government bodies or private organisations in a position to do this by making funds available and by providing technical information. In addition, according to the 7th Conclusion, the State is responsible for passing the necessary legislation. Indeed, the development of social employment in our modern society more and more urgently requires a national framework fixing the organisational structures, working conditions and circumstances and government contributions. In the Netherlands, such a law was passed in 1967. The national expenditure on social employment rose to approximately 340 m. guilders in 1969, i.e. 1½% of the national budget or 0,36% of the national income. The number of disabled persons engaged on social employment was approximately 44,000 at the end of that year.

3.3. The responsibility of industry

Industry, or the firms of which it consists, already does a great deal to provide work for the disabled, although their efforts are generally limited to members of their own staff who become partially unfit for work during the period of their service. The larger firms in particular take a great deal of trouble to get their employees back to work after a serious accident or illness.

However, this possibility has clearly defined limits, as long as the firms have to meet all the extra costs arising themselves. These costs do not primarily consist of wages, since to a great extent partial compensation is possible in this connection by social welfare payments to which those concerned are entitled. Frequently, more guidance and instruction is necessary, there are more interruptions in the work, and sometimes technical equipment has to be adapted. It is therefore usually a good idea to provide, on the lines of the Swedish system of "semi-sheltered employment", financial aid to firms employing disabled persons and making special arrangements for them, in particular in the form of specialised guidance. However, the translation of this idea into practice still seems to encounter difficulties which hold back progress.

4. Forms of organisation

4.1. The workshop

By this we mean a workshop in which disabled persons perform work of either a craft or an industrial nature. Other features are in many cases that the products are very diverse - anything saleable is seized upon - and that the work is simple or very simple.

This picture is not very satisfactory. From the economic point of view, craft-type work is extremely unprofitable; and psychologically, it places a stigma on the workshop. The wide diversity of products, especially if the workshop has only a small number of workers, means that the quantities produced are very small, and this reduces the financial viability still further. Furthermore, the fact that only a small number of activities of a more complicated nature are carried on means that many disabled persons either refuse placement in a social (sheltered) workshop or perform work which is below their abilities. As I see it, the ideal is a workshop forming a permanent part of a modern factory (but adapted to the requirements of the physically disabled), located in an industrial area in the vicinity of other workshops; at least 100 disabled employees, using up-to-date technical equipment, turn out industrial products or semi-products in massive quantities, where possible on a contract basis for commercial undertakings, so as to avoid the risks of production for the market; the diversity of the activities makes it possible for some of the disabled persons to perform semi-skilled or skilled work; the workshop is not known externally as a "workshop" but as a "firm", with a selected name.

4.2. Other forms of organisation

It is still the case that sheltered or social employment is often presented in the literature and in reports as equivalent to work in a social (sheltered) workshop. This is understandable historically, but is damagingly one-sided as far as the disabled are concerned. Just as not all "fit" persons are suited to manual work in workshops, neither are all disabled persons. For them too there must be other possibilities.

In the Netherlands, in addition to workshops, there are various other types of work situations, viz. for manual workers:

Horticulture (cultivation of vegetables, flowers and herbs); Units performing light outdoor work relating to municipal open spaces or recreation facilities (the laying-out and improvement of parks, playgrounds, cycle tracks and footpaths, etc., construction and improvement of youth hostels, etc.);

and for brain-workers:

the "administrative centre", where permanent or temporary activities such as registration, statistics, financial administration, etc., are carried out under contract for the local authority and/or industry;

Braille transcription of reading matter for the blind;

Individual positions in government and public institutions (museums, archives, statistical offices, scientific institutions, etc.).

A certain amount of home-work is also organised for both classes of workers, but only for disabled persons who are unable to travel.

Some figures:

At the end of 1969 approximately 44.000 persons were engaged in social employment, this figure breaking down as follows:

a) in workshops	67%
b) in nurseries and gardens	4%
c) in other outdoor projects	19%
d) miscellaneous projects for brain-workers	9%

Of the approximately 44.000 employees, nearly 45% were physically handicapped, nearly 30% mentally retarded and nearly 20% psychiatric patients or ex-patients.

5. Selection for placement

5.1. Who qualifies for placement in social employment?

In some countries and areas, sheltered employment is confined to specific categories of disabled persons, e.g. the blind, the physically handicapped, epileptics or the mentally retarded. This is not satisfactory in present-day society. A large proportion of, in particular, people with acquired handicaps then never get a chance to secure a suitable job. I have particularly in mind the thousands of people with organic disorders, of the cardio-vascular system, the respiratory organs or the digestive organs, or who suffer from such troubles as rheumatism and arthritis.

It is also out of tune with modern times to maintain separate workshops for specific groups of disabled persons, e.g. the blind, these being heavily subsidised, whilst providing no funds for other categories. The obvious course is to mix the different groups of handicaps, for the sake of greater efficiency, through the constitution of larger units. Separation is justified only where certain types of disabled persons give rise to psychological opposition. In general this applies only to the severely mentally retarded and certain types of mentally ill persons.

Of course, not all disabled persons are suitable for placement in social employment. There is an upper and a lower limit. Those whose disablement is so slight that they are acceptable for ordinary industry or another organisation on the labour market do not belong in social employment. At most, they can be placed there for a limited period of adaptation, so that they can be more readily placed in a normal occupation afterwards.

Other unsuitable groups are those whose working ability is too small. It is very difficult to define "too small" by any standard yardstick. For certain forms of manual work, the measure applied in the Netherlands in practice is "one third of a reasonable minimum output under normal working conditions". In many cases the limit must be established by intuition. If it is not clear how far a disabled person is capable of regular work, he can be accepted for a trial period.

5.2. The selection procedure

Except in the case of limitation to specific categories of very severely disabled persons, the question of the correct selection (admission) procedure takes on greater importance. The following must be established by this procedure:

a) wether a particular subject can be placed;
b) what types of work he can and cannot perform, and under what conditions;
c) in what working situation he can best be employed.

This determination cannot be effected by a single person (e.g. a doctor), but requires a team of experts in different fields, i.e. preferably in addition to the doctor (where possible the industrial doctor specialising in social employment), the personnel manager or industrial social worker of the social employment organisation, a work study expert and a special officer from the public labour exchange service. In certain cases the assistance of other experts must also be called in, e.g. a medical specialist, psychologist or specialist social worker.

6. Assistance with adaptation

6.1. The necessity for adaptation

Disabled persons must usually adapt in many respects, especially in the initial period after their placement:

In the early stages, getting up early in the morning, travelling and spending several hours in the working environment involves considerable physical effort.

Returning to society demands a considerable mental adjustment, after the disabled person has for a long time been alone or only in the company of his wife or closest relatives; this means mental effort.

Movement of the body or limbs is often difficult and sometimes painful; only gradually does it become easier.

The disabled person has largely lost his working skill in consequence of his accident or illness. He must endeavour to recover it by practice, but this also involves effort. In addition, he must frequently learn skills which he never had before the onset of his disability, because he previously did different work.

At the same time he has to cope with the mortifying fact that henceforth he has to go through life as a disabled person, that he cannot perform many activities or cannot perform them so well or so fast as before, and that he can now only work under adapted, sheltered conditions.

6.2. Assistance

It is a clear consequence of the foregoing that accomodation to the needs and requirements of disabled workers is essential. Those responsible must realise this; in the appointment of senior officials, from the highest to the lowest level, just as much attention must be given to social as to technical qualities.

It is very important that those responsible, including the staff experts of the social employment organisation - if any - should meet together regularly for discussion as a team. The agenda should include not only general administrative matters (working conditions, production, safety and hygiene, etc.) but also the needs and difficulties of individual employees. In this connection the type and difficulty of their work naturally plays an important part. These must as far as possible correspond to possibilities: not beyond their abilities, but preferably also not below them! On this point, I should like to remind you of what I said earlier (in 2.1.2.) about the development of working capacities. One should in fact never be satisfied with what a disabled person achieves in his work. One should be constantly on the look-out for chances to encourage and help him to improve the quality and speed of his work. Nothing is so fatal to social employment as a static situation, in which everyone remains at the same post for years.

Of course it is a fine thing if this gives a disabled person a chance to change to a job in a normal environment.

It is essential that those in charge should not raise objections to this, as is sometimes done for dubious reasons; instead they should encourage such a step as far as possible.

On the other hand it would be wrong to expect overmuch. When social employment has been operating for a period of several years and the "best" disabled workers have been able to transfer to the general labour market, the chances for those remaining are of course much less.

P. LENNIG

1. Introduction

Part II, Article 15, of the European Social Charter, signed by all member countries of the Council of Europe, states: "In order to assure effective exercise of the right of the physically or mentally disabled to vocational training, integration and re-integration, the contracting parties undertake:

1. to adopt suitable measures for the provision of training facilities, if necessary also in the form of public and private special institutions;
2. to take suitable steps for the engagement of disabled persons in jobs, in particular through the establishment of special labour exchanges, the possibility of employment under conditions protected from competition, and measures to encourage employers to engage disabled workers."

The European Social Charter refers, among other points, to a working environment with particular protection from competition or which is sheltered in general. This clearly indicates that in addition to the general labour market, there is a second, sheltered labour market. In this connection, we must make a reservation, since the concept of the sheltered working environment is not commonly used in the Federal Republic of Germany, the notion of a "workshop for the disabled" having become current in a relatively short time both in practice and in legislation.

2. Definition of the sheltered environment: "Workshops for the disabled"

In a joint recommendation, dating from 1967, of the Workshops Committee of the Bundesvereinigung der Lebenshilfe and the Committee for Labour and Vocational Advice of the Deutsche Vereinigung für Rehabilitation, workshops for the disabled are defined as follows:

> "Workshops for the disabled are places of work which provide jobs for persons who on account of their disablement are unable or not yet able or not yet again able to seek employment on the labour market at large, and which endaevour to secure the optimum progress of the disabled with respect to their personality and capabilities.
>
> The jobs concerned may be permanent or occupied by disabled persons only for as long as is necessary until it becomes possible for them to become integrated on the general labour market.
>
> The workshop is open to all disabled persons who appear socially able to integrate into the workshop community."

2.1. Aim and tasks

According to the above recommendation, with reference to Recommendation 99, Section VIII of the I.L.O. to the International Seminar on Sheltered Employment, Saltsjöbaden, Sweden, 1964, and the International Symposium on Sheltered Workshops, Frankfurt/Main, 1966, the following basic principles apply to a workshop for the disabled:

2.1.1. The entitlement of even the severely disabled to work.

2.1.2. The right to participation in the life of the community.

2.1.3. The combination of temporary and permanent positions.

2.1.4. The combination of the fields of training and production.

2.1.5. The mixing of persons with different kinds of handicaps.

The aim and task of a workshop for disabled persons is to find a reasonable, personally satisfying and useful occupation for the handicapped person, wether in settling-in activity, on the general labour market or in a workshop for the disabled, in an open or closed institution or provided with suitable work to be done at home.

3. Persons qualifying

To define which classes of disabled persons qualify for admission to a workshop for the disabled, it is not possible to take as the basis the usual classification of handicaps - physical, mental, psychological, etc. - but instead the starting point must be the definition of the work, because the persons concerned generally have one or more functional disabilities and after leaving special schools or completing all possible medical treatment cannot, or cannot yet, offer themselves on the general labour market, or cannot be assisted in classical rehabilitation units.

3.1. Types of disability

Practical experience has shown that in a large workshop with a variety of different facilities it is possible to cope with an extensive range of types and degrees of disability (e.g. organic brain damage, sequelae of diseases contracted in infancy, multiple cerebral damage, epilepsy, Rh disorders, etc.).

According to recent work by Schomburg and Bläsing (reference 1), in a group of disabled persons examined, 19% had two disabilities, 35,7% had three disabilities, 26% had four disabilities, 9,2% had five disabilities and o,4%

had six disabilities. Thus a disabled person with one handicap only is the exception, whilst multiple disablement is the rule; see also Bach (reference 2).

Apart from this principle of mixing, special institutions will always remain necessary in particular areas, e.g. acute mental patients.

3.2. Age, sex and mixing

For obvious reasons, a disabled person should be admitted to a workshop for the disabled only after a foundation period of instruction at a special school. This means that in most cases the young disabled person is admitted after appropriate assessment and testing as necessary at about age 18. There is no upper age limit. The relatively young average age of persons in West German workshops for the disabled is no doubt attributable to the very recent introduction of this specialised field of rehabilitation (statistics based on personal experience reveal an average age of 23½ for a group of 230 disabled persons).

The ratio of the sexes in the workshops for the disabled is 55% males to 45% females. In most cases men and women work together. Only a small number of institutions with a rigid traditional approach still separate the sexes.

It seems doubtful wether in our present context there are any jobs which are the specific province of one sex, except for very heavy physical labour.

3.3. Social position -
Family, hostel or closed institution

However valuable the work itself is, one cannot disregard the equally important aspects of the disabled person's social environment, accomodation, residence and leisure activities. This may give rise to tensions (the well known positive and negative social interactions), of which the parents of the disabled persons and the workshop staff have to be made aware.

Practical experience shows that disabled persons can be integrated relatively easily as regards work, but often fall down in the social field referred to above.

According to estimates, 80% live with their families, 15% in hostels and 5% in closed institutions; they travel to the workshops every day, some of them coming independently by public transport and others having to be brought to the workshop and taken home.

3.4. Numbers

In spring 1971, there were 230 workshops with 10.000 places in the Federal Republic of Germany.

According to statistics from different parts of the country, the demand varies from a minimum of o,5 places per 1.000 total population. The demand is expected to double over the next 10 years.

The estimated demand in the Federal Republic (population approximately 60.000.000) is as follows:

10.000 places available now
30.000 places to cover immediate needs
60.000 places in 10 years' time.

This requires total funds to be made available of 2.500 million DM (reference 3).

Estimates of the cost of providing one work-place range from 25.000 to 30.000 DM.

According to partially completed regional projects, the optimum size of workshop is 120 places. The radius of the catchment area should not exceed 25 km. Associations of workshops are planned for more thinly populated areas.

4. Methods and programmes

Understandably, no generally valid method structure can impose itself in the field of workshops for the disabled. For this reason we can only deal with the basic conditions, and even these only partially.

4.1. Basic conditions

Since the workshops are to offer the disabled person both training and work suited to his individual abilities and inclinations, as well as the nature and severity of his disability, they must be large enough to provide an optimum range of different possibilities.

Practical personal experience, and also the results of planning work (reference 4) indicate considerable advantages for larger units. Only these units have a sufficient financial basis for the recruitment of staff with qualifications beyond those of the group leader and workshop leader, such as social workers, specialist doctors, psychologists, speech therapists, etc.

This factor is closely bound up with the economic location of the workshop, its accessibility to potential customer firms and general transport.

Other essential conditions are specific requirements as to constructional layout, the technical equipment of the working positions, tools, facilities and machinery, to offer the disabled person an optimum range of possibilities. The controlling body should also have substantial funds available.

The overriding consideration, however, must be that the workshop should be planned and organised for the disabled person and not the other way round.

4.2. The workshop

A workshop for the disabled must be regarded in this context as a general term describing and combining all the tasks mentioned above. It is to be seen as a foundation. Let us at this point draw attention to a particular feature of such a workshop as an instrument of social and employment policy.

It differs from the normal world of labour in that the persons involved remain constant, whilst the production is interchangeable; on the general labour market, on the other hand, the production is fixed and the workers are interchangeable. A workshop for the disabled does not merely signify a supply of the diverse activities, jobs and goods of industry and commerce, but also denotes a wide variety of working possibilities on the commercial or administrative level for the disabled, as well as suitable outdoor work.

4.3. Analogous institutions

Apart from the workshop, which provides jobs and permanent positions, the following analogous institutions exist:

4.3.1. "Self-contained departments" for the disabled within industrial firms, these being either under the control of the workshops or fully integrated.

4.3.2. Sheltered individual jobs on the general labour market, and also in the public service.

4.3.3. The provision of appropriate work to be performed at home.

4.4. Organisation

If a workshop for the disabled is to succeed in the tasks described above, it is essential for it to have a modern administrative organisational structure, with the mobility of an industrial firm and without the rigidity of a bureaucratic public institution. The organisation must be transparent and open to new and sometimes progressive philosophies.

4.5. Examples of production; the labour market

What objects are possible and suitable for the work of a workshop for the disabled? The answer is that in our highly technical industrial society with its division of labour, the workshop is in a uniquely favourable position. We shall not digress into detailed descriptions here. Practical experience shows that suitable work of any degree of difficulty, in every sector of industry and production, can be performed by disabled persons on the basis of suitable job preparation and analysis.

There are three basic possibilities:

Industrial commissions
Commissions for services
Autonomous production with marketing.

It is impossible in the context of this contribution to go into all details of the revolution in the possibilities of work within our highly developed industrial society. In rehabilitation in general and in workshops for the disabled in particular, we encounter over and over again philosophies and conceptions based on the notion that we still live in a mediaeval-type society of crafts and guilds.

This attitude is shared by other authors, who regard the progress of automation as a nightmare spectre looming over workshops for the disabled and the rehabilitation of the disabled as a whole.

Technical progress and economic change do not signify any limitation on the vocational settlement of the disabled; on the contrary, they bring with them wider and more appropriate possibilities for vocational activity and success.

4.6. Special methods

The most important principle in the training and settling-in of the disabled is that progress must be accomplished in small, methodical steps and without big jumps. The following stages may be distinguished:

Observation and assessment
Settling-in
Training
Detailed practical training
Actual work.

A point to be borne in mind here is that every job has the character of a challenge (its stimulation potential), and this factor should be deliberately utilised as motivation. All forms of training should be practical and presented in clearly understandable form. Complex working cycles must be broken down into individual steps. The interrelationships must be understandable or made to be understandable. The training and settling-in must be based on the disabled person and not on the production.

4.7. Staff and specialists

As in all areas of general rehabilitation, the training of a disabled person in a workshop can succeed only if sufficient staff with the appropriate professional specialisations are available.

No institutions for the professional education of such staff yet exist. At the present time attempts are being made to fill this gap by such means as courses and weekend seminars for already qualified staff.

Collaboration of the advisory team, as is the custom in general rehabilitation, is necessary here too. The persons concerned comprise not only the immediate workshop staff but also the specialist doctor, specialist psychologist and the social worker attached to the labour exchange and special disablement departments of the public social welfare authorities.

4.8. Collaboration: public relations

In addition to the collaboration necessary, which, of course, must also involve the family of the disabled person, an objective public relations effort is also needed if it is to be possible to integrate him. This has nothing to do with sentimental and emotional image-creation or appeals to the presumed benevolence of the non-disabled citizen.

5. Legal foundations; social security

The rights of the disabled as mentioned above are enshrined in two basic laws in the Federal Republic.

5.1. The Furtherance of Labour Law (Arbeitsförderungsgesetz)

This law, with the Rehabilitation Ordinance of 2 February 1970, applies to the disabled in particular and provides for considerable encouragement of institutional and individual aid.

The essential condition for the application of this law is that the disabled person must be capable of integration on the general labour market or of a permanent job in the workshop. The law also expects the disabled person to work for at least 30 hours per week, that the object of his work should be of economic value, and that he should receive reasonable remuneration. For this purpose it is necessary for the workshops, according to their configuration, to be capable of economic working; they should approximate to conditions in factories in the economy as a whole and make it possible for the disabled person to achieve full integration.

For this purpose the workshops should offer working conditions as close as possible to those obtaining in industry, be equipped with their own tools and machinery, aim at economic operation, have a modern organisational structure and take advantage of technical progress.

5.2. The Federal Social Aid Law (Bundessozialhilfegesetz)

This law, in the formulation of its second amendment of 1 October 1969, provides in a separate subsection for general and particular assistance for the disabled, irrespective of the cause of their disablement, where the disabled person is unable to help himself and does not receive the necessary aid from other quarters.

In addition to the current financing of workshops for the disabled, there is a possibility of individual aid for single purchases of orthopaedic or other facilities and possible continuous assistance with living expenses.

Mixed financing under both laws in a single workshop for the disabled is possible.

5.3. Accident, sickness and old age pension insurance

The disabled persons working in the workshops are insured against industrial accidents under the insurance arrangements of the employers' associations.

Sickness insurance is available for persons in regular employment as "self-insured" persons or through the "family insurance" scheme.

Action is in hand to include disabled persons who receive only a token wage in the compulsory sickness insurance scheme as "self-insured" persons.

Regarding old age pensions, there is at present no unified arrangement. Where a regular employment situation exists, even if this is in a workshop, there is no problem. In other cases, there is no legal entitlement, since the general old age pension is subject to contributions having been paid. For the severely disabled, the old age pension is paid from social welfare funds.

5.4. Institutional aid

In the financing of workshops for the disabled as a whole, a distinction must be made between institutional and individual aid. Institutional aid is provided in the form either of loans or of grants, but it is conditional upon a sometimes substantial contribution by the controlling body. Institutional aid is provided for the construction of workshops, their equipment and special technical facilities. The latter is also possible if the disabled person is active on the general labour market.

5.5. Individual aid

In addition there is the possibility of individual aid to the disabled person in the form of subventions during the preparatory settling-in period or in the form of a settling-in grant or "integration subvention" to the disabled person's employer, to compensate for his reduced output. In addition to this, action is in hand to extend the provisions of the Law on the Severely Mutilated to the disabled.

6. Output and remuneration

In this context the notion of the output of the disabled person cannot be regarded only fron the one-sided viewpoint of our "output-orientated" society.

For a disabled person, output and achievement may mean that he is able to travel by himself to a workshop for the disabled or to take an active part in the life of the community in such a workshop, without accomplishing any particular empirically measurable productive output. It therefore appears necessary to distinguish between social achievement and work output as regards both measurement of this output or achievement and remuneration.

There is a wide gamut ranging from pocket money through token wages and output-dependent wages to a subsidised social wage independent of output, designed primarily to meet the needs of the disabled person.

It is an urgent necessity to find a reasonable and just solution to this problem.

(1) SCHOMBURG und BLAESING "Empfehlungen zur Erziehung mehrfach-behinderter Kinder" pädagogischer Ausschuss der Bundesvereinigung Lebenshilfe für das geistig behinderte Kind, Leitung Prof. BACH.

(Recommendations for the education of multiply-handicapped children) Pedagogical Committee of the Federal Society for Assistance to Mentally Handicapped Children, Director: Prof. BACH.

(2) BACH "pädagogische und psychologische Grundfragen der Erziehung mehrfachbehinderter Kinder" in Beiträgen zur Körperbehindertenfürsorge, Seite 98.

(Basic pedagogical and psychological problems in the education of multiply-handicapped children) page 98.

(3) Planungsgruppe des Landessozialamtes Niedersachsen, Hannover, in Verbindung mit dem Landesverband der Lebenshilfe.

(Planning Group of the Land Social Bureau of Lower Saxony Hanover, in association with the Land Society for Assistance to Mentally Handicapped Children).

(4) Planungsgruppe A.a.O. - (Planning Group) (loc. cit.)

- Verzeichnis über die Werkstätten für Behinderte in der BRD, Deutsche Vereinigung für die Rehabilitation Behinderter e.V. - DE.VG. - 69 Heidelberg 1, Friedrich Ebert Anlage 9, Prof. JOCHHEIM.

  (Directory of Workshops for the handicapped in the Federal Republic of Germany, German Society for the Rehabilitation of the Disabled)

- Ergänzbares Handbuch "Werkstatt für Behinderte" Bundesvereinigung der Lebenshilfe für geistig Behinderte vom 31.10.1969.

  (Manual for completion "Workshop for the handicapped" Federal Association for Assistance to the Mentally Handicapped - 31.10.1969)

DISCUSSION

O. MESSER

The European Social Charter lays down the right of disabled persons to rehabilitation and, as soon as they are working again, to all social rights under the Charter, which they need more than non-disabled persons. Resettled persons working in workshops for disabled people need, as supporting social measures, particularly

pragmatic social integration measures which put them as far as possible on the same footing as their fellow citizens

- appropriate designe of living conditions in a framework as close as possible to family conditions;
- with regard to leisure;
- with regard to holidays;
- with regard to participation in the life of the community and the society in which they live.

In addition to the tasks of the governments and those of the international organisations in this field, society itself has special obligations to its disabled citizens.

F. MONTES

In view of the technological changes and the development of automation, it seems to me that disabled persons will have an increasingly difficult task in establishing themselves in the so-called normal labour market. It therefore seems that, side by side the more and more productive and competitive industrial sectors, protected industrial sectors ought also to be developed.

From this point of view several problems arise:

1. The sheltered workshop must be as similar as possible to a normal workshop, that is, its aim must be essentially occupational. But since in a civilised society it is our human duty not to dissociate ourselves from anyone, it is essential to create special workshops the aim of which will be primarily social in order to give work, or at least activity, to disabled persons suffering from particularly serious physical or psychic handicaps.

2. Remuneration: The means which the disabled person must have in order to live when he is working in a sheltered workshop must be of two kinds:

   a) direct remuneration for his output;
   b) a supplementary wage, so that these two elements together guarantee every disabled worker a level of resources the minimum of which must be at least equal to the minimum inter-trade gross wage (French definition of minimum wage).

3. Social coverage: It seems to me particularly important that disabled workers should be subject to the same obligations and have the same rights as other workers, that is, that they should pay taxes and contributions related to their incomes.

   I think that one special aspect of these obligations ought to be emphasised. In order to guarantee the disabled person's future rights (health insurance, pension, etc.) I think that both the direct wage and the supplementary wage should be subject to contribution.

4. Concluding this statement, I should like to express the hope that the European Community will

> study and go thoroughly into the ideas expressed this morning concerning the necessary fusion of disablement insurance and insurance against industrial accidents. It is particularly important that the level of social coverage should be dependent on the results of the handicap and not on its causes. Now the present situation is abnormal in that it is those disabled victims of war or of industrial accidents who are in receipt of the highest compensatory incomes who also have first priority for employment. The logical thing would be the converse, that is, that priority of employment should be given to those who have the smallest resources to live on.

I have no illusions about the fact that the fusion of the different systems will take time. In France we took the Bastille in 1789, but everyone knows that in order to arrive at the system of social protection at present existing in the Netherlands we still have to destroy many Bastilles.

E.A. MUELLER

Resettlement and rehabilitation of disabled persons presupposes the availability of scientifically developed methods of measuring the physical and psychic stress on the job and the available ability of the disabled person and for improving that ability. This is not a question of an undifferentiated sporting ability to achieve peak performances but of a continuous performance on a shift basis on the job which it is reasonable to expect in a balanced state of all human functions without permanent fatigue. The basis for the determination of this continuous performance limit of endurance of a specific worker on his job has been established, in particular, by the Max Planck Institute for Industrial Physiology at Dortmund.

The same institute was the first to study the reduction in the performance capacity of wearers of artificial limbs and the possibility of increasing this performance by analysis and improvement of the efficiency of the artificial limbs. Efforts of this kind are still rare and sporadic. There is a lack of research centres permanently engaged in studying the innumerable problems of the reacquisition and preservation of performance capacity in the cases of the manifold forms of disablement, and simultaneously seeking the technical bases for the optimisation of the widest possible variety of jobs with a view to making them suitable for disabled workers.

The creation, maintenance and coordination of such research centres on a European and world-wide basis is the most important prerequisites for the optimum and intensive development of rehabilitation.

A.H. HEERING

I should like to touch on Mr. MONTES' remark about the problem of remuneration. He wishes to divide this into two parts:

a) an economically determined part
b) a supplementary part up to a specific minimum amount.

I see great drawbacks to this - the argument is an old one! My main objections are:

1. It is difficult to implement technically, because one cannot base the "economic" part solely on the performance of the disabled worker but one must also take into account the cost of extra facilities (guidance, the adaptation of the job or of

machines, etc.).

2. It is humiliating for the disabled person if he is constantly reminded by the dual nature of the remuneration that he only earns a small amount and is given the supplementary sum of money for nothing.

POINTS OF VIEW

Chairmen: Mr. MESSER

Directeur adjoint des Affaires Economiques et Sociales
Conseil de l'Europe
France

and Mr. MARINELLO

Presidente
Associazione Nazionale Mutilati ed Invalidi del Lavoro
Italia

Authors: E. GLOMBIG : point if view of the disabled
R. BALME and R. WEBER : point of view of the employers
A. BORSTLAP and J. DE GENDT : point of view of workers
H. BASTENIER, J. GODARD : Point of view of industrial medicine.

REPORTS

E. GLOMBIG

1. Introduction

The debate about the European Economic and Monetary Union leading up to approval of the Multi-Stage Plan by the Council of Ministers was dominated by considerations of monetary and financial policy. The Werner Report (Report to the Council and Commission on the phased Implementation of the Economic and Monetary Union in the Community), earlier national reports and now the Resolution of the Council and Representatives of the Member States' Governments adopted on 8/9.2.1971, refer only vaguely to the requirements of social policy integration - social policy being understood here as the passive and active reduction of risks (social insurance and employment policy) - or simply draw attention to studies such as the draft of the Third Programme for Medium Term Economic Policy which contains a few passages on social policy. The Commission is alone in having given effective consideration to the "Connexion between social policy and other Community policies" in its studies. Since the Community's foundation, social statistics and social policy have been allowed an important place in official EEC publications, but so far it has proved impossible to eliminate the far-reaching national differences. The EEC Treaty itself contains few binding provisions in the social sphere: with the exception of certain individual sectors, Art. 117 does not specifically call for "harmonization of social regulations" but expects this to come about through the "effects of the Common Market".

Practical experience has shown that the instruments of social policy are very difficult to harmonize. The national social security systems which have grown up in the course of time still differ very widely as they always have done. The processes of approximation of social policy which are now under way, together with institutional regulations should, however, prevent the attempt to establish an Economic and Monetary Union in the EEC from foundering on the reef of serious social disequilibrium. A settlement of the problems of rehabilitation would be a means for the EEC Council to give effective content to its "first step towards a solution of problems which take priority in the regional and structural sphere" proposed for the first stage of development towards economic union. In the light of this fact, the European Symposium in Luxembourg could be of great assistance to the Council.

2. What are the prospects for a comprehensive rehabilitation programme in the European Communities?

This is all the more true as on 13 March 1969, the Council of Ministers of Labour in the EEC States, acting on a German initiative, called upon the Commission to prepare and lay before the Council without delay a "plan of action" for the medical, occupational and social integration or reintegration of the more than 5 million physically or mentally disabled or handicapped persons in the Community. The Ministers of Labour made it clear that they did not want an academic social study of the traditional kind from the Commission but an effective political plan or action for close, practical cooperation in the sphere of rehabilitation.

This unanimous mandate given by all the member States in the Council to the Commission has so far not aroused the attention among the general public in Germany and Europe which it deserves because of its significance for social, economic and employment policy and its importance for European integration. The prospects opened by a European rehabilitation programme for rehabilitation as such and also for closer cooperation between the member States on social policy (which has encountered many difficulties up to now), depend in large measure on the extent to which the Commission is able to prepare a modern, forward-looking programme of action which meets with the approval of all the member States in the Council. The aims, tasks and proposals contained in this plan of action must be precise enough to serve as a basis for practical cooperation. This is a particularly difficult problem which the Commission can only solve if it forgets all dogmatic differences of opinion with the Council on the content of the social policy objectives contained in the Treaties of Paris and Rome and on the manner in which these objectives are to be attained, and manages to reconcile the interests of the member States in a rehabilitation programme which is of benefit to the Community as a whole.

In this context the preparation of a questionnaire to evaluate the present state of rehabilitation measures in the member States and the formation of a group of experts to advise the Commission in the drafting of a long term rehabilitation programme, are to be welcomed as extremely positive steps. I set great store by the initiative of the Social Affairs Directorate of the EEC Commission because the EEC has in the past neglected the subject of rehabilitation and left it to other international organizations. I therefore regret that the governments of the Member States were not invited in good time to participate in the preparation for the Luxembourg symposium. In Germany's case at least, the Federal Government is responsible for coordinating occupational rehabilitation, and is therefore best able to provide a survey of the situation regarding rehabilitation in the Federal Republic. The position is presumably the same in other member States.

It is essential to make sure that none of the EEC's projects amount to duplication, i.e. subjects must not be examined which have already been dealt with or are now being studied by other international organizations (such as the Council of Europe, ILO or ISRD).

In selecting rehabilitation projects for the Community, it is first necessary to make a detailed study of the practical objective of the measures and the practical results which are likely to accrue to the Member States. A start on concrete projects must always be given preference over complicated surveys or efforts to lay down theoretical definitions. This consideration also applies to the questionnaire which is now being prepared by the Directorate General for Social Affairs. The draft contains a whole series of questions whose meaning is far from clear. It would be simpler and more effective to ask governments and experts in the member States to name the subjects which they feel could usefully be dealt with by the Community. Some questions which need to be answered are set out below:

a) To what extent is the principle of equal treatment for all disabled persons, regardless of the origin of the disability, already applied in the individual member States?

b) Can the optimal organization for rehabilitation be determined on the basis of a comparison of forms of organization in the member States?

c) Can the legal conditions be created in individual member States for the joint staffing of common rehabilitation centres, in particular special centres for specific kinds of illness and disability?

d) Can research and documentation on rehabilitation be coordinated?

e) Would it be possible to organize an exchange of experts for advanced training of rehabilitation staff?

f) Can common criteria be laid down for the creation and general recognition of a European passport for disabled persons in the member States?

As you know, the EEC has not yet studied detailed problems of rehabilitation. All that has been done is to make arrangements, within the framework of the social fund, for cross-charging between States for certain services in the sphere of individual rehabilitation. In my opinion the European symposium in Luxembourg should inform the Commission on current problems of rehabilitation in Europe. Backed by experience in the Council, I believe that it is preferable not to give too much attention to basic principles. Instead a number of concrete subjects should be actively studied.

Through its Joint Committee on the Integration and Reintegration of Disabled Persons, the Council of Europe has been dealing with rehabilitation for almost 20 years. The outcome of its work has been some 30 recommendations and resolutions which have not particularly helped rehabilitation in the individual countries. Clearly this is not the right approach. It will of course be impossible to manage without a survey of the rehabilitation situation in individual member States. But we should not confine ourselves to this single aspect and wait until a survey is completed in a few years time. It would be much better to highlight a few practical points - along the lines of the German programme for action - and set to work on them immediately. These points might include (in addition to the questions raised in a-f above) activation of the social fund for the institutional side of rehabilitation and the definition of activities separate from those of the Council of Europe and other international organisations.

3. The German programme for action

In his governmental statement to the German Bundestag on 28.10.1969, Chancellor Brandt outlined the following pragmatic approach to rehabilitation: "The Federal Government will attempt to take stronger measures to give new prospects to disabled and handicapped persons in the professional and social sphere, whenever this is possible."

Following Chancellor Brandt's governmental statement, the Federal Minister of Labour, Mr. Walter Arendt, announced the Government's programme for action to facilitate the rehabilitation of disabled persons on 14.4.1970 in Wiesbaden. The Minister took advantage of his presence at the first meeting of members of the Federal Working Party on Rehabilitation to express the Government's goodwill and readiness to cooperate on a basis of confidence not only with the Working Party on Rehabilitation but also with all persons responsible for rehabilitation. He also explained the Government's ideas on the subject of rehabilitation.

I should like to draw attention to some of the principles underlying the programme for action which seem important to me:

1. The programme for action is based on the structured systems of rehabilitation consisting of independent centres in the Federal Republic. It does not intend

to interfere with existing responsibilities but to point out the lines which are to be followed in common.

2. The programme for action covers the whole range of rehabilitation: the medical, educational - for which the Länder and municipalities are mainly responsible- and social aspects of rehabilitation.

It therefore goes beyond the areas for which the Federal Minister of Labour and Federal Government are responsible.

The programme for action covers the individual and institutional aspects of rehabilitation. Two priorities are indicated for the individual sector:

a) The administrative procedure must be smooth and continuous. Disabled persons must be given guidance at an early stage and introduced to the process of rehabilitation. It must not be the responsibility of the disabled person to apply himself to the authorities which meet the costs of treatment. The Federal Working Party on Rehabilitation will have a great deal to do in this particular area of social insurance.

b) The different rehabilitation services must be harmonized as quickly as possible; the principle of causality must be overcome. This is particularly important in the case of maintenance payments made during occupational rehabilitation. But it also applies to services designed to facilitate the social integration of the disabled.

In the institutional sector it is necessary to establish a tightly knit system of rehabilitation establishments, ranging from clinics and hospitals to special establishments for specific types of disability as well as training and retraining centres and special kindergartens, schools and workshops and other centres in which the disabled are employed.

The Federal Government's programme for action requires the cooperation of all establishments concerned with rehabilitation in the Federal State, Länder and municipalities, the legal authorities responsible for rehabilitation, both sides of industry, the churches, welfare associations and organizations for injured and disabled persons and their families. Above all it needs the support of each individual disabled person who must have the willpower and readiness to overcome his disability. The aim of the Federal Government's programme for action is to give the disabled the assistance which they need. This is also part of our common European Responsibility and not least a special responsibility for the national Parliaments.

For the first time since the foundation of the Federal Republic, an attempt is being made to develop a comprehensive rehabilitation programme. The range of this programme shows that the rehabilitation of disabled children cannot be isolated from the rehabilitation of disabled adults. The rehabilitation work for children is simply one component of the rehabilitation efforts made throughout the life span of the disabled. I realize that the effectiveness of efforts made for children is of decisive importance in terms of the development of disabled persons in later life. This is particularly true of adequate school and if possible university education which, as we have seen, is the responsibility of the Länder in the Federal Republic.

But our efforts to help the disabled adults must also be successfully completed because - however strange this may sound - the true dilemma of rehabilitation of disabled children (who will be the adults of tomorrow) arises when they grow up. Disabled adults, especially those suffering from a serious disability, require continuing rehabilitation work, sometimes to an even greater extent when the protection and assistance of the family cease to be available.

I therefore maintain that the problem of rehabilitating disabled children is inseparable from the problem of rehabilitating disabled adults; there is one single problem: the rehabilitation of all disabled persons. I believe that this fact must be recognized by all those who devote their activity to the meritorious task of rehabilitation.

4. The interest of member States in rehabilitation

The basic interest of the member States in rehabilitation announced in the EEC Council has a social aspect, namely the need to give an appropriate place in our society to every individual - even those who are handicapped or disabled - in line with his knowledge, abilities and reserves of performance, while respecting his human dignity. But there are also vital reasons of economic and employment policy which underlie this interest.

4.1. The growth of premature invalidity

The number of premature invalids in the Community countries is constantly rising. Premature invalids are men and women of normal working age who have to quit their employment prematurely because of war injury, industrial and traffic accidents, occupational illness or some other cause of disability. They have to live primarily on a pension, public welfare (social aid) or social assistance of a different kind.

In the Federal Republic alone there are already 1.5 million premature invalids out of a total of 4 million disabled persons. Some 60-80.000 children with physical, mental or psychological disabilities are born every year in the Federal Republic and require care and assistance in special establishments. More than 2 million industrial accidents and some 20.000 occupational illness cases are reported to the industrial trade associations every year. More than 460.000 persons are injured in traffic accidents on German roads every year. In addition there is an unknown number of cases of other illnesses which lead to permanent disability. Taken together these causes mean that more than 200.000 persons become unable to work or earn their living in the Federal Republic every year and are isolated completely or partially from the economic process. A survey conducted in France in March 1962 showed close on 1.7 million disabled persons, including 1 million with a serious physical disability and 100.000 with grave mental disability. In Belgium every 10th person out of a total population of 10 million is disabled. Some 270.000 persons, i.e. 3% of the Belgian population are mentally disabled. Of these some 50.000 persons are unable or no longer able to lead an independent life without constant outside assistance and care. There must be between 4 and 5 million premature invalids on the territory of all 6 member States who cannot engage in active work. The total number of disabled persons in the Community must be well in excess of 5 million.

The growing number of premature invalids is a heavy burden on the member States. Social insurance and the other social services have to pay thousands of millions of DM for their support in the long run, to say nothing of the economic benefit which is lost through their premature cessation of activity. In addition there is the employment policy aspect of the problem. Admittedly in Italy there is still a relatively high percentage of able-bodied unemployed, but taken as a whole the demand for labour (especially for skilled manpower) is constantly rising in all Community countries. Even Italy, although it has the highest rate of unemployment in the EEC, is already suffering from a real shortage of skilled labour. Even those countries which still have a reserve of manpower - generally due to structural reasons - will not in the long run be able to allow tens if not hundreds of thousands of persons to leave the employment market prematurely each year as a result of traffic or industrial accidents or the illnesses of our modern civilization.

4.2. Economic significance of rehabilitation

The Federal Government above all, but also the French government have set themselves the aim of cutting premature invalidity decisively in their countries in the next few years and enabling the greatest possible number of disabled persons to return - through measures of occupational rehabilitation which must already begin on their sick bed - to the working environment as fully competitive members and to rejoin seociety on an equal footing with their fellows.

From the economic and financial standpoints, rehabilitation is a typical example of a social policy which not only costs money but also benefits the economy. Rehabilitation restores valuable manpower permanently to the economy. The burden on the social security system is relieved by rehabilitation and in addition each disabled person who is integrated or reintegrated in the working environment contributes through his activity to economic growth. He pays taxes and social insurance contributions on his wage or salary. American and German studies have shown that rehabilitation is one of the best investments the state can make. It was found for instance in the USA that for every dollar spent on rehabilitation, 10 dollars are returned to the state. This does not even take into account all the other economic benefits derived. Another survey also carried out in the United States with the aim of measuring the allround benefit to the economy, reached the conclusion that every dollar spent on rehabilitation yields an economic benefit of 48 dollars in terms of new manpower and saving of welfare payments. Spread over the whole period, this represents a 4800% return on the invested capital.

5. Conclusions

Optimal rehabilitation must be provided for disabled persons in the EEC States. In spite of all the successes achieved in the sphere of rehabilitation, it is more than ever necessary to create the legal and organizational basis for a logical system of rehabilitation measures and establishments based on practical requirements; this system must enable all disabled persons, irrespective of the nature, extent and cause of their disability, to call upon all the services, assistance and institutions which are to achieve the best results in integrating or reintegrating them in their work, occupation and in society. The way in which the EEC States solve the social problems of disabled, sick and weak persons will be an important reflection of their humanity.

R. WEBER

The employment of disabled persons; employers' attitudes

Modern social policy is based on the principles that prevention is better than cure and that individuals must be helped to overcome social weakness. Helping men to help themselves, fostering the use of remaining abilities, appealing to human self respect and activating all facets of the personality are the main weapons of our social policy.

The conclusion to be drawn from the first principle is that measures whci are capable of preventing human suffering and damage must be given precedence over measures of assistance once damage has been incurred. This means that prevention must take priority over rehabilitation. Companies must for instance be at pains to take every available measure to prevent industrial accidents; in this way they will not only avoid human suffering but also eliminate economic loss which is frequently incalculable. Industrial accidents interfere with the production flow and disturb normal operations; the victim is temporarily and sometimes even permanently unable to work so that he and his family have to be supported by public funds.

These considerations also show, however, that the measures of retraining and rehabilitation must not be viewed in isolation. They are part of the social security system. Prevention and rehabilitation are therefore very closely related. Experience of rehabilitation can show what preventive measures should be taken. If we find for example that certain industrial accidents are constantly repeated and entail specific consequences in each case, we must consider how such accidents and their consequences can be avoided. This also applies of course to road accidents and illnesses which result in disability.

The second principle of our modern social policy (see above) implies that we no longer wish merely to support disabled persons by "charity" or social assistance but instead propose to make those persons able to face the competition of normal life in spite of their disability so that they cease to be dependent on public assistance. It would be unrealistic to suppose that preventive measures can rule out disability completely. Hereditary damage, illness, industrial accidents and road accidents which are inevitable in view of the increasing density of modern traffic, together with premature phenomena of deterioration mean that rehabilitation measures will always be necessary.

The aim of making disabled individuals fit again to participate in a competitive life is not merely an economic necessity but also an ethical duty corresponding to the need to respect human dignity. This aim will never be achieved if a disabled person has the impression of being a victim who deserves sympathy and must live on the alms of society. Indeed experience shows that disabled persons have a particularly strong need for compensation. They make vigorous efforts to overcome their limitations and prove to themselves and to those around them that they are still full members of human society.

These basic considerations already show that rehabilitation is a problem for the whole of society; it cannot be the function of isolated groups to integrate disabled persons back fully into normal society by medical, vocational and social measures. This also means, however, that the community must bear the cost of such reintegration.

The measures involved are varied, but vocational rehabilitation is particularly important because it is often a precondition for reintegration into a job or profession. This reintegration is a decisive factor in fixing the objectives of rehabilitation; vocational training is not merely a way of enabling disabled persons to earn their own living without special support. It also enables the disabled individual to confirm his own value by acquiring professional qualifications and the means of improving his professional and social position. When we consider that in our modern industrial society the place of work is increasingly becoming the focal point of social and human contacts, the significance of rational and successful reintegration of the disabled person into professional life cannot be too highly emphasized.

This problem can, however, only be solved through confident cooperation with the employers. Employers must not merely make suitable jobs available for disabled persons as a social duty; this social duty must also correspond to the dictates of economic reality. Sympathy for persons who have suffered serious injury (a feeling which is an any case painful to the individuals concerned) must not be the main consideration; attention must concentrate instead on integrating the disabled person as smoothly as possible into the production process since the primary aim of every concern in the public or private sector is to produce or provide a service. Against this background there is no conflict of interest between efforts to provide work for disabled persons and the primary function of a company. Indeed the two aims coincide in large measure.

These basic considerations show that legal measures to ensure the employment of disabled persons are not of vital importance. The decisive impetus in favour of the fullest possible vocational integration of such persons must come from the general development of employment, the successes of medical and professional rehabilitation and the elimination of prejudices which still exist against disabled persons. Although it would no doubt be preferable to overcome these prejudices through repeated objective information and convincing arguments, legal measures to secure employment for disabled persons will still be necessary in some measure. That is why legal requirements are often placed on employers not only to grant jobs to disabled persons but also to integrate them into the company as a function of their strength of will and aptitudes, and grant them every prospect of vocational and social advancement.

In this context I do, however, consider it undesirable to allow considerations of competition to influence legal regulations. Competition among companies may be distorted by a whole range of factors. It cannot be the task of the legislator to eliminate - when drafting social policy laws - individual factors which might lead to a distortion of competition. When it comes to the employment of disabled persons, it would be contrary to the principles of modern rehabilitation to assume that the employing company would suffer economic damage; indeed such an assumption is hostile to rehabilitation because it supposes that the disabled person has a reduced capacity, in other words is less valuable to the company for which he works. At the same time this assumption supports existing prejudices against the employment of disabled individuals.

The attitude shown to these problems in the USA is most rational. In that country it is assumed that the disabled person is once again completely competitive on the labour market after rehabilitation and therefore requires no special protection for his reintegration in a profession; nor does he need any special protection for his employment. This opinion is clearly supported by actual experience. F.W. Taylor for example carried out surveys in more than 100 American companies employing many thousands of persons. He concluded that some two thirds of the physically disabled employees have the same production rate as colleagues suffering from no physical damage. 24 per cent of the disabled persons even had a higher productivity than unimpaired colleagues, while only 10 per cent showed below average performance. However the value of an employee is not determined solely by directly measurable output. Taylor's survey shows that accident rates and errors are often lower among disabled workers than among normal employees.

This is a result of the need for compensation mentioned earlier, i.e. the greater willingness to make an effort in order to maintain social status or move up in the social hierarchy and find satisfaction in more solid performance and increasingly skilled work. Finally Taylor found that disabled persons change jobs less frequently than their colleagues. It would be wrong to conclude, however, that their professional mobility and level of qualifications must accordingly be lower than among normal employees. The willingness and ability to adapt oneself to new technical developments has nothing to do with the readiness to change jobs.

Compulsory legal measures and sanctions in connexion with the employment of disabled persons are less important than encouragement which should be given by law for companies to employ such persons. For example, provisional integration payments could be made from public funds on a temporary basis until the disabled person is able to provide full and normal services to his company. A balancing payment could be given to the employer if he pays the disabled employee a full wage even though his output is temporarily lower, or else an allowance granted to the employee until his performance reaches the level at which he is able to earn a full wage.

It is particularly important to make legal provision to ensure that disabled persons - irrespective of the cause of their disability - are prepared for working life in line with their ability and inclinations. In view of the dynamic nature of modern technical and economic development, vocational rehabilitation should not only help to reintegrate the disabled person but also assist his vocational advancement as far as possible.

If repeated emphasis is placed on the need to restore the ability of disabled individuals to compete on the labour market, it must still be made clear that this objective cannot be defined in objective and subjective terms. In times of full or even over-employment, the standards used to determine wether an individual has been fully rehabilitated vocationally will be objectively different from those applied in times of underemployment. In subjective terms the performance capacity of non-disabled persons is not a measurable value. There are wide performance variations between normal workers which will tend to be accepted the greater the demand for personnel is in the economy. It is accordingly impossible to define the point at which a disabled person is completely rehabilitated professionally.

One thing is clear, however: as our medical and technical development advances, this point is being pushed upwards so that the prospects for complete vocational rehabilitation are improving. New medical knowledge is leading to an increasingly complete return to normal health. Technical development which is causing man to be relieved of heavy physical work by the introduction of machines and automatic systems, offers better possibilities for disabled persons. Our economy with its emphasis on the division of labour and specialization is creating new occupations and possibilities of employment for disabled persons. Then again, new technological aids are constantly being developed which enable handicapped persons to work on jobs that have previously been closed to them. Paralyzed and blind persons provide a good example. Medical progress has substantially cut mortality among persons who are paralyzed in the lower half of their body while technical developments have resulted in an increasing number of occupational possibilities for paralytics who are confined to wheelchairs so that their participation in vocational training is increasing all the time. Whereas the jobs open to blind persons used to be very few, modern technical development has extended their working range substantially. The blind brush-binder and mat weaver belongs largely to the past; blind persons are no longer confined to jobs as masseurs, musicians and telephonists and can consider many other occupations today. These developments must be taken into account in a flexible system of laws.

The above remarks have already shown the significance of practical vocational training measures for disabled persons. It should be remembered that in the vast majority of cases of injury, rehabilitation is completed with medical rehabilitation. Once he recovers his health, the patient is generally able to return to his former job. In the Federal Republic of Germany, only about 18% of all patients require a phase of vocational retraining after medical rehabilitation.

Guidance is one of the first measures of vocational rehabilitation. As in the case of non-disabled persons, individual aptitude and inclination on the one hand and the development of the labour market on the other must all be taken into account; the final decesion must always lie with the disabled person himself as to wether he wishes to follow training and if so what kind of training, at what time and in which particular establishment.

A few other factors also come into play in the case of disabled persons. The number of jobs open to them are relatively restricted depending on the exact nature of the disability. Regional mobility is also frequently reduced. Finally it must be remembered that the adult disabled person who has e.g. been affected by an accident has already pursued an active life and there are accordingly points of reference for the rehabilitation plan. In strictly conceptual terms, rehabilitation must always be preceded by exhabilitation; however the best rehabilitation consists in avoiding exhabilitation altogether. In view of the uniformity of the rehabilitation process it is essential to prevent rehabilitation from leading to isolation in the phase of professional rehabilitation; this would have results opposite to those which are sought after.

From the employer's point of view, the labour market policy component is particularly important because it is decisive - in addition to individual inclinations and abilities - in determining the extent to which a disabled person can ultimately be reintegrated into professional life.

This means that the process of vocational training results in an individual who is required by the economy. During the guidance stage, close contact is.therefore already necessary with the economy and the vocational training measures must be matched to the needs of industry.

Vocational rehabilitation is a problem which has existed since prehistory and will continue to exist in the 21st century - an age in which the futurologists seem to live already. It is clearly not easy to reconcile rehabilitation with the real needs of industrial practice and economic development. While some people believe that the training of mat weavers and brush binders must continue, others have visions of an economy which will soon be fully automated - although they disregard the fact that the conversion of scientific and technical knowledge into industrial practice is ultimately always an economic decision.

The rehabilitation plan must always be based on the activity pursued by the disabled person hitherto. In the first place an attempt will be made to employ the person concerned in his old profession and at his former place of work, if necessary by providing special working aids and safety devices. The employer too has an interest in this and will therefore often be willing to make available the necessary aids to adaptation. Even if a person cannot be employed on his former job, employment in the same company is still desirable.

It is often forgotten that the company has a primary function to perform in the sphere of vocational rehabilitation. In the interest of the affected person, transfer to a different company should be avoided by taking the necessary measures of vocational adaptation within the previous organization and providing employment possibilities by a more expedient labour organization. More explanatory work and the institution of legal encouragement are, however, necessary in this sector to develop an interest in this problem among employers.

If the company is unable to take its own measures of vocational adaptation for the disabled person, the possibility should be examined of providing vocational training in the area in which he lives in public or other training establishments,

Here too it will generally be possible for the disabled person to take part in appropriate courses in the company of unimpaired students.

These considerations are based on the need to make every effort to keep the disabled individual within the surroundings to which he is accustomed and protect him against isolation and detachment. A person who has suffered a heavy blow will be best able to overcome the shock if the process of readaptation takes place in the accustomed context of his family, friends and working colleagues so that he becomes aware that there has been no change in his social status and he can compete with normal individuals in the process of vocational training. This procedure also excludes the mental strains which arise if a disabled person is surrounded for a long time by other patients only.

It would of course be illusory to suppose that the needs of vocational rehabilitation have been dealt with exhaustively in the above remarks. Even if training or retraining in a vocational rehabilitation establishment is theoretically the final resort, it is nevertheless certain that a not inconsiderable number of victims, especially those suffering from a severe disability and who are unable to continue in their previous profession or in a similar job, will have to fall back on vocational training measures in boarding establishments.

In order to counter the risk of isolation which this entails, a decentralized system of establishments is essential. The disabled person should then be able to visit his family as often as possible so that contact.with his previous environment is not broken. On the other hand the rehabilitation establishments must offer a wide choice of vocational training measures and these measures must also make allowance for the whole range of disabilities. This requirement of course prevents excessive decentralization of the establishments. The two factors must therefore be reconciled in the best possible manner.

The rehabilitation establishment necessarily entails the disadvantage of being remote from practical life, to the extent that vocational training measures cannot be combined with productive employment. For considerations of vocational education, a productive activity should be maintained whenever possible even in the context of a course of training or retraining.

However, this is not always possible. The more difficult it is, the more remote the rehabilitation establishment will be from the dynamics of practical working life. Machines, equipment and working methods run the risk of becoming obsolete and the process of vocational training will then pass by the needs of practical life. In such cases it is essential to maintain close contact with practical reality. The training personnel in rehabilitation establishments should therefore regularly take practical courses in private industry; training plans and examinations organized by neutral bodies outside the rehabilitation centre are an important means of ensuring that the measures of vocational training are in close touch with practical life.

The time schedule for the training measures should also be carefully arranged. All the persons involved have a great interest in this being the case. The disabled person would like to continue his professional life as soon as possible in the accustomed setting, and earn his own living again instead of living on assistance in the rehabilitation centre. The authority which supplies the funds has an interest in the training course being completed quickly. And because of the constant shortage of skilled personnel, employers themselves would like new staff to be made available as soon as possible.

Disabled adults have often pursued a professional activity beforehand and are therefore able to follow a short, vocational training course. During such a course it is possible to omit many items which must be included in the training of young people. Adults are already acquainted with the professional world. New knowledge and skills can therefore be imparted in a concentrated form. Adults often already have skills and knowledge which can be used in a completely new profession. The "building box" or modular system has therefore often proved its value in vocational training establishments. In preparing the rehabilitation plan, it is first decided which additional skills and knowledge must be imparted, having regard to existing abilities. This naturally leads to highly personalized training.

In determining the duration of the training course, it is, however, also necessary to remember that disabled persons have a particular need for a secure occupation and the question of professional mobility must be considered. If the demand for labour is buoyant, a disabled person who has only followed a short course of training will certainly find a job. But it would be wrong to assume that the labour market will always be in this state; in addition disabled persons do not find satisfaction if their work is too narrowly defined because their prospects of vocational development will not be great enough.

Even if regional and professional mobility are necessarily restricted in the case of disabled persons this does not make it possible for the vocational training course to disregard the fact that a dynamic economy increasingly calls upon employees to adapt themselves to new developments. Disabled persons must not only be given the ability but also the willingness to accept such adaptation during the process of vocational training. This does not of course mean that in future they will "migrate" constantly from company to company. Nor does it mean that they must undergo permanent retraining in the sense of a complete adaptation to new jobs. Even a company which continually faces the requirements of technical and economic development is interested in a consolidation and continuity of the conditions of employment. Even a modern economy cannot cope with permanent fluctuation and retraining. Professional mobility has nothing to do with the static or dynamic factors in conditions of employment. But employers must in future expect disabled persons too to offer the necessary personal and professional conditions for permanent adaptation. This adaptation does not primarily consist in a movement from one place of work to another; on the contrary it is primarily completed at the place of work in a given company. It must, however, be remembered that the requirements for adaptation are highly varied. The effects of technical progress differ widely from one branch of industry to another; some sectors are better able than others to exploit new technical and scientific knowledge. The rate and extent of structural change due to new patterns of utilization, production processes and the introduction of new materials also vary from sector to sector.

The training programmes of rehabilitation centres must make allowance for these factors. It is therefore inadvisable to place excessive emphasis on "future-oriented" jobs because the latter require a particularly high level of willingness and ability to accept changes; but disabled persons frequently lack this characteristic because of their disability and often because of their advanced age.

The professional training course must give disabled persons the same qualifications as their unimpaired colleagues. The purpose of rehabilitation measures would not be fulfilled if the disabled person merely became a second class skilled worker. The course of training should therefore lead up to a final examination arranged by a neutral centre. The disabled person must be required to meet the same standards as any other candidate. Nothing should be "given" to him. Ultimately this will strengthen his self-confidence and feeling of his own value. The examiners may of course make special allowance for uncontrollable disabilities. If the vocational training measures are not conducted directly in a company or in cooperation with the latter, it is extremely important to find jobs for persons completing the course. Every effort must be made to give the disabled person the best possible vocational chances by procuring a suitable appointment for him; the possibility of vocational advancement must also be considered.

To enable an employer to judge the abilities of the disabled person accurately, he should be given documentation or information on the physical aptitudes and mental and psychological attitudes of the person concerned. The psychological evaluation of a disabled person is particularly important for practical purposes. Because of the wide variety and high degree of specialization of our economic life, the disabled individual is scarcely in a position to evaluate his own professional possibilities. He cannot define the activity which he will be able to perform with the reserves of ability he still has. One person may overestimate his possibilities while another may underestimate them. The supervisory personnel responsible for the work of disabled individuals in a company must therefore make sure to give the necessary encouragement while at the same time damping excessive expectations. It is vitally important to eliminate prejudice on the part of staff and superiors against disabled persons. Such prejudice does of course occur against certain severe forms of disability. Above all practical resistance is encountered when disabled persons are included in a group earnings agreement, because the other personnel feel that the disabled individual will force down the level of performance.

The working climate is particularly important to a disabled person. Frequently he will have developed a labile and therefore sensitive awareness of himself over the years. Those around him must accept or at least tolerate this fact. He must gradually regain self-confidence and lose his fear or isolation. This will often only prove possible if those around him are tolerant and accept him into their community so that ultimately he has a feeling of satisfaction. Once the vocational aptitude of the disabled person has been determined, it is necessary to find an appropriate job and place of work for him; his place of work must be equipped in such a way that he can work easily and safely. The employer must therefore equip and maintain working areas, equipment, machines and tools with special reference to safety and arrange operations in such a way that optimum employment is provided for the disabled person. The place of work must also be equipped with the necessary technical aids. In view of our modern knowledge of personnel management, this is merely a natural prerequisite for the rational employment of staff.

This knowledge can, however, only be converted into practice by cooperation between the company management, works representatives, industrial doctor, works welfare department and the official responsible for industrial safety.

The adaptation of the place of work to the different forms of disability is one of the major functions of companies when disabled persons have to be integrated into the normal operations. Working processes can sometimes be altered and brought into line with the ability of handicapped persons. Machines and fixtures can today easily be adapted for operation on the basis of remaining physical skills. One hand units etc. enable manual skill to be increased while carefully designed seats and retaining devices can reduce muscle strain; limited physical mobility can be replaced if necessary by adapting the transport distances or lessening transport requirements. Modern techniques are available to make difficult conditions of work from which the disabled person is liable to suffer more tolerable, e.g. dust, noise, heat, cold or heavy vibrations. The working arrangements must always be rationally chosen and measures taken to ensure that the disabled person is not called upon to do more than he can reasonably cope with for long periods.

The ultimate aim of vocational integration of disabled persons must always be employment at an acceptable place of work under normal conditions. Special workshops for disabled persons do have a place in the overall system of social assistance, but they should be considered primarily as establishments for reintegration in which individuals can be prepared during a transitional period for a normal professional life. The permanent employment of disabled persons in workshops designed specially for them would ultimately result in their isolation rather than integration. Special workshops for disabled persons should therefore only be used for adaptation to normal employment. They should be a "transit station" for the disabled. It will of course remain necessary to create workshops for those individuals who cannot or cannot yet be employed under normal labour market conditions.

It will not always be possible to employ disabled persons in medium or large industrial concerns, although it does seem at first sight that the large companies with their wide range of jobs offer the best conditions for the employment of disabled individuals, especially as rationalized and mechanized companies no longer require physical strength of their workers as used to be the case. Mental mobility and manual dexterity are often more important today. On the other hand in partially automated companies where work is tied down to a specific operating speed, it is not always possible to find jobs for disabled persons. However, small and medium companies making wide demands on personnel will often meet the needs of disabled persons who have a thorough training. The better and more varied their training has been, the easier it will be for them to find employment in companies of any size.

The ideal job, tailor-made for a disabled individual, will exist in very few cases indeed. A desk is certainly not ideal e.g. for persons with an amputated leg, because it involves very little movement. On the other hand this will not be a reason to retrain an intellectual worker who has lost a leg for a manual activity simply because it would make him move more. The same considerations apply to other types of disability and places of work which do not allow sufficient physical training essential for disabled persons.

The physical balance which is urgently necessary can only be achieved outside the company, e.g. by taking part in sport for handicapped persons. Although sport has far greater importance for the health and capability of disabled persons than for ordinary individuals, its many possibilities are not always fully exploited as yet. Disabled persons require more information on the subject, while encouragement and assistance must be given through legislation and public measures and greater attention focussed on this subject during the process of rehabilitation. A gymnasium, swimming pool and sports field are essential in a modern rehabilitation establishment. Medical and vocational rehabilitation must convince disabled persons of the need for compensatory physical activity to maintain their level of performance and health; certain resistance will have to be overcome.

Disabled persons cannot be merely left to their fate once they are integrated into a company. Welfare at the place of work calls, however, for great tact and care. On the one hand the disabled person must not be given the impression that he needs permanent assistance, but on the other he must be aware that he can obtain help when he needs it. Disabled persons experience difficulties as they grow older which sometimes make retraining necessary again. But great care is called for in this respect. A transfer from one company to another when the employee is already fairly old is generally undesirable, because the adaptation to completely new working conditions is not always easy for older people. In addition it ceases to be possible for an outside agency to find a suitable post because of the inability or unwillingness to make the necessary adaptation.

In many instances the aim of making a disabled person completely competitive again on the labour market cannot be achieved even in times of full employment. The procurement of a completely secure position cannot be guaranteed.

When it can be expected that the disabled person will be in a position to do a fully satisfactory job after a certain training period, attempts should always be made to find a normal working position for him after transitional employment in a workshop for disabled persons. The most difficult problem is presented by disabled persons who, even having regard to the fact that the performance norm applied in a company may be highly variable, will always remain well below this norm. The modern solution is to employ them in workshops for the disabled, but here too - even though output will be relatively low - attempts should be made to work productively if not economically. In such cases it is the duty of industrial companies to transfer suitable production processes to such workshops. Although they will always require public subsidies, it would also be possible to attach these workshops to large companies if a continuous supply of work from the latter can be guaranteed. In both cases the companies should be given encouragement by legal provisions.

The range of possibilities indicated above shows that there is no patent remedy in the sphere of rehabilitation. Politics must always keep in close touch with what is possible under practical conditions; this is particularly true of the various forms of social policy because we are concerned here primarily with men and their highly varied requirements, problems and needs. They cannot be forced into a set pattern and we should not be guided by mechanistic thought patterns in the sphere of rehabilitation and try to manipulate men. Our methods of helping them must be as varied as their own disabilities and needs.

R. BALME

The employers' point of view

This is a difficult and complex problem. Numerous aspects of it have already been dealt with by the various employers who represent the majority of the different participants in this meeting.

Any solution can only be collective.

The various representatives of the different C.E.E.P. delegations have been unable, in the time at their disposal, to meet to decide what might have been the C.E.E.P's present position with regard to this problem. Consequently I shall only make a few suggestions, which may complement some already made, but personal suggestions nevertheless, on the basis of notes made during the discussion. However, since the employers' viewpoint has already been expressed in what they have done, I shall refer you, particularly as regards the C.E.E.P., to the contributions already made by representatives of the Charbonnages de France, the S.N.C.F. and those of the Italian or German delegates of the C.E.E.P.

I have observed that during the last two days the subjects dealt with have included references to:

(i) present-day laws, their differences, and the development which has taken place or is desired in legal concepts: for instance, that the principle of finality ought to replace the principle of causality;

(ii) the need to get down to the permanent adaptation of knowledge in relation to the capacity and intelligence of the disabled;

(iii) the need to ensure that training structures are as close as possible to actual working structures;

(iv) teaching techniques (didactics, group work, audio-visual teaching);

(v) the need to think of integrating the worker into, and in relation to, his original environment;

(vi) the appearance of new occupations connected with the everincreasing use of computers or electronic equipment;

(vii) wether pay should be related to the established output or the real effort of the worker.

All these problems are by no means among the least important of those which now face industrial society as a whole, wether as regards the disabled or the non-disabled - an all too large percentage of whom one can say will unfortunately soon be joining the ranks of the former, for although the number of disabled may be decreasing in some spheres it is increasing in others.

Every aspect of our society is involved.

If we consider only roads and transport, let us bear in mind that:

(i) at the Vienna congress in early May it was said that although the number of fatal work accidents was still very substantial (about 100.000), the number of fatal accidents which occurred on the journey between home and the place of work was even greater;

(ii) in France in 1970, there were 15.000 fatal road accidents and 300.000 persons were injured. We can imagine that an appreciable proportion of the latter will have joined the ranks of the existing disabled.

In this social environment in which efforts on behalf of the disabled are still more often than not a matter of isolated initiatives, in which the employer himself often experiences difficulty when faced with the development of the knowledge used or to be used at work to provide for the requirements of one and all, what can an employer try to do?

1) Undoubtedly, to make the best use in the economic, political, social, cultural and technical context of those disabled persons who are engaged in production work or who may become so engaged.

When it is known, either now or at some future date (as some speakers have pointed out) that up to 80% of disabled persons can be reintegrated and rehabilitated (even though after some degree of selection) a certain measure of optimism might be in order. This knowledge still needs to be widely disseminated, so that no further effort is wasted in achieving what has already been successfully achieved elsewhere. Is it too much to hope that the underlying motives for "industrial secrecy" will not be invoked in this context?

2) Maximise schemes for prevention and detection at work, so as to limit the number of future disabled persons who will swell the ranks of those already disabled...and bring us back again to the preceding problem.

Doctors, social workers, safety specialists - but psychologists, sociologists and sucklike also - ask themselves the same questions as the employer, and often experience difficulty in operating in a milieu which is rapidly developing, but which it is nevertheless necessary to know thoroughly if the most effective preventive and curative schemes are to be applied to it.

While, for instance, it seems obviously necessary when dealing with safety at work to remember that "safety begins on the drawing board", one finds increasingly that any future permanent effort must depend on both:

(i) a knowledge of the trade (development, including technique and technology), and

(ii) a better knowledge of behaviour in various dangerous situations; as well as on:

(iii) the improvement of the climate and general conditions of work.

These various preoccupations are all equally important, since great skill in the trade may result in the taking of risks or in difficult relations with the less skilled. In other words, it is sometimes just as important to consider the sociological and psychological as the technical aspects of the trade, if not more so.

The same is true of all problems connected with work. Nor does this concept, linked with the complex relations of working situations, become more easy to master by reason of becoming increasingly obvious; for as far as consideration of motivation and behaviour are concerned the employer feels that he is at a crossroad of stimuli and preoccupations which deserve the attention of everyone and are worth mentioning here.

a) Although as stated the number of disabled may represent 15% of the active population of the Community, they do not lack family and social links with this active population, who do not leave behind them their behaviour and motivation when they pass through the factory gate or the office door. The problems of prevention, reintegration and care in respect of the 15% will progress as a function of the degree of interest accorded to them by the sum total of the objectives pursued by that population.

b) The gradual raising of the school age results in people starting work increasingly late in life. Nor is it certain that the training received at school and at home before starting work facilitates a spontaneous interest in the problems of the disabled and their reintegration into the working scene. A certain kind of "competition" may even result in a lack or diminution of consideration for those less strong or more weak.

c) Although people are starting work increasingly late in life, their attitudes are not those of bygone days. Average expectation of life is increasing. Knowledge is "eroded" more rapidly. The progress of the printing press was not impeded, and neither will that of data-processing and of the new structures of training or information be impeded. The working scene is changing. The jobs and functions which were thought up or laid down in the past and allocated to the different age groups will have to be the subject of "re-thinking". It will become increasingly expedient and necessary to plan jobs in terms of mankind, its different ages and different production capacities.

May we not hope that, within the range of our preoccupations research may be undertaken with a view to facilitating integration of the different kinds of disabled persons?

d) In our societies "work" is still the place where the concepts of "success" and "failure" occur, where the difference is measured between the position in society hoped for, dreamed of or desired...and the position in society achieved or perceived. It is also the scene of the quest for and exercise of power: in other words, the place of work remains the primary centre of economic, ideological and political confrontation. The place to be assigned and the attention to be paid to the problems of the disabled are linked with present or future social and employment policies in the Community.

e) The concepts of adaptation or conversion that have been mentioned in relation to "the disabled" are the same as those currently used in connection with the preoccupation with "continuous" or "permanent" training at all hierarchical and functional levels. And the definition of the disabled chosen for this meeting: "those whose expected performance differs from the performance they are able to give" could quite easily be applied to each and every one of us, as far as the programmes for giving us training, refresher courses, further education and maintaining knowledge and behaviour, are concerned.

The problems on integrating, adapting or readapting disabled persons for the return to work meet up with the problems of integrating, adapting or converting the whole active population in which the concept of a "maladjusted person" (with the increasing number of conditions known as "depressive" at the highest levels of responsibility) is becoming increasingly synonymous with the expression "disabled person".

Problems of permanent training and supplementary training arise for these different structures - wether disabled or not - in a new society in which it is not only a case of posing the problems of adapting work to man or of the firm to socio-economic conditions, but of integrating - against the background of the reciprocal rights and duties of the individual and the community - revised and more realistic concepts of solidarity, freed from outmoded sentimentality.

Wether it is a question of courses for the reintegration, conversion and adaptation of disabled persons, or of conversion, adaptation, information and refresher courses at work, it seems that the more the consideration of the technical problems is combined with the study and consideration of the psychological or sociological aspects, the more clearly defined and the more successful these various courses are. Everyone wishes to, and must, take part in tackling his present condition and development.

The consideration of these various stimuli of industrial society and the attention to be paid to the extent of the various nuisances it implies, might perhaps prompt governments, institutions and employers to inquire into the factors which need to be taken into account in order to instigate and implement within firms and governments a genuine policy of modern management of the problems of persons and personnel - encouraging the furtherance of the human side of firms - and resulting in permanent efforts to gain a better knowledge of and a greater skill in the management of human communities.

A. BORSTLAP

Chapter I INTRODUCTION

I.1 Before World War II care of the disabled was limited to medical treatment and such associated services as the setting-up and maintaining of establishments where the disabled could live and be looked after. The purpose of this care was keeping alive a man or woman who, because of a handicap, was no longer able to live with his own family; wether there was any sense or value in this life either for the person concerned or for society as a whole, was not really taken into account.

The allowances were barely enough to maintain physical existence; usually, the disabled person was still reliant on support from his relatives, or on Church or public charity.

Activities aimed at occupational rehabilitation and reintegrating the disabled person into working community were undertaken only if, bearing in mind his age and the productive capacity remaining after his disablement, the often costly and time-consuming business of rehabilitation seemed economically justifiable.

I.2 After the Second World War the idea gained ground that work can, quite apart from its economic value, also have an intrinsic value for the worker himself. Through his daily work, a man keeps a living contact with the outside world, a contact through which he gives as well as receives. By working, a man demonstrates his value both to society and to himself.

The large numbers of disabled resulting from the casualties of war (and including a high percentage of young people) presented a challenge to rehabilitation, not only because of the economic contribution this group of persons could still make but also from a more personal viewpoint - because of the emptiness of life that would face these war victims if they were to be condemned for the rest of their days to be shut up in establishments where they could be looked after but where nothing further would be asked of them.

It is notable that this attention to the value of work for the worker himself became a guiding principle in rehabilitation precisely at a time when philosophers and theologians were warning against overprizing work as the be-all and end-all of human existence. The reconstruction of a war-shattered Western Europe was being pursued with vigour. The urge to gain, or regain, personal prosperity went hand in hand with a desire to set the sources of national prosperity flowing again - so working for one's own wellbeing was, at one and the same time, working in the national or regional interest.

Work, and the income it brought, filled many people's lives to overflowing. The manager who spent his weekend going through a pile of work brought back from the office in his briefcase was highly regarded, even if he did neglect his family. The heart attack or duodenal ulcer it brought him were - even though painful - so many insignia.

Those concerned with the social sciences, in particular, raised objections to this scheme of things. Doctors, philosophers and theologians asked themselves wether it was right that life, for many people, meant nothing except work. Is leisure really nothing more than the pause for rest needed for charging up the natteries? Would not enjoying art make a man richer than doing paid overtime? In a word, the people who studied human behaviour were asking, increasingly loudly, wether work ought to be the means of of living, or the reason for living.

At the same time, work for every disabled person who was capable of it, even in a modest way, became the aim of innumerable attempts at rehabilitation.

I.3 The answer to this apparent contradiction probably lies in the thought that a life composed entirely of leisure will be just as lacking in human satisfaction as one filled with nothing but work. The personal value of work lies in its compulsory nature; it is a requirement imposed by others, and in this respect differs from, for instance, the pursuing of a hobby that may also involve a great deal of work, The value of leisure, on the other hand, is determined to some extent by the curtailment and limitation of it, by the time that "belongs to others" and is at other people's disposal.

I.4 But enough of philosophy - let us get back to the disabled, who have a human right to have the capacities they still possess put to use. This human right must serve as a starting-point for occupational rehabilitation and placement in employment. The decisive aspect, in the question of wether or not a scheme of rehabilitation and re-employment is to be set up for a particular disabled person, should not be primarily the economic gain that can be expected from what that person can be enabled to achieve. What matters is wether the work can bring personal satisfaction and fulfilment to the handicapped person concerned - even though the work may call for so much preparation and special arrangements, and permanent guidance that the costs of reintegrating the person will be nowhere near covered by the returns from his work. Obviously the extra costs incurred in getting a disabled person back to work cannot be a charge on the firm with whom he is placed - these are costs which should, as a matter of principle, be borne by the community, or by industrial society as a whole.

Chapter II REEMPLOYMENT OF THE DISABLED

II.1 Activities directed towards reemployment

II.1.1 Getting a disabled person back into employment calls for more than just developing the work-capabilities he still has. It will besides, in many cases, be necessary to work on his mental attitudes. Not wanting to work again is often a far greater barrier to reintegration than not being able to work again.

Besides this, however, the environment in which the rehabilitated person is going to work must be suitable, or be made suitable, for receiving the new and less-capable fellow-worker (see also Para. 2 of the present chapter).

II.1.2 Medical and occupational rehabilitation should form one part of the social-services package to which the social insurance scheme gives a claim. They involve expenditure to finance treatment which offers the prospect of a cessation or reduction in the expenditure on maintenance benefit which a disabled person can claim through his social insurance.

A situation like that obtaining in the Netherlands where, at least for employed persons, the costs of rehabilitation are met from the same fund that pays the disablement benefit, has the concomitant advantage that a rehabilitation scheme which, by itself, is costly will be accepted by the social insurance authorities precisely because this apparently expensive scheme can lead to savings in expenditure on benefit payments that will be many times greater. Although the experience of financing rehabilitation under the WAO, or Wet Arbeidsongeschiktheid (= Disablement Act), is still very scanty and recent - the Act came into force on 1 July 1967 - it does appear to bear out the view that this rehabilitation, including the upkeep of a special rehabilitation centre, has helped to reduce costs and will in the long run be certain to reduce costs.

It is regrettable that in the Netherlands, four years after the WAO came into effect for persons in employment, there are still no comparable arrangements for those working on their own account.

It has besides become clear that the term "medical and occupational rehabilitation" must not be interpreted too narrowly. Alongside vocational training, refresher courses and retraining for a different occupation there must also be provision for including the initial period back at work in the process of rehabilitation and financing it accordingly - even if only to overcome the "stagefright" of the disabled person concerned.

Finally, the success or failure of rehabilitation will be affected by the attitude of the disabled person's family doctor. The general practitioner, who unlike the medical officer of the social insurance authorities has the full confidence of the patient, should have the plan of rehabilitation explained to him and should be asked to help the patient overcome his resistance to accepting rehabilitation.

II.1.3 Up to now we have been talking about bringing the skills and capabilities of the disabled person back to a level where he can be made a useful worker in the production process.

The psychological preparation for a return to work is at least as important, however. Objections of a financial kind - such as working for a lower wage than before - can easily be solved. It is more difficult to deal with the psychological blocks, often expressed in the form of disbelief in the possibility of becoming partially capable of working again. The first reaction of anyone who has had to give up work because of illness or accident, and then after being "out of the swim" often for a long time has to face up to the fact that he will never be able to return fully to his old trade, is to accept that he is completely incapable of working again. An ill or disabled person who knows that 100% recovery is out of the question certainly needs extra determination and courage if he is to submit cheerfully and willingly to a course of rehabilitation treatment that will sometimes be long, sometimes be painful and will invariably be tiring and strenuous. No-one can, from the outset, give him the assurance that the treatment will succeed; even less can one offer a guarantee that, once rehabilitated, he will again be able to earn his own living by his work. What we are asking the patient to do is to trade the certainty of a reasonable disablement benefit for the uncertainty of acquiring new skills and the risks of going back to taking an active part in the struggle for existence.

Here people talk, indeed, of the "anti-rehabilitation effect" of social legislation. Anyone who can make a valid claim to a stable allowance related to his old income which, though it may not entirely remove the necessity of going out to work again, at least substantially reduces it, will tend to overestimate the effort and cooperation needed from him for rehabilitation, and to underestimate the extra income, over and above his benefit, that his hard work can bring.

In such cases compulsion will achieve very little. Threats can be made to reduce or cut off the benefit if the partially-disabled person continues to refuse to cooperate in rehabilitation. But in doing so the social insurance authorities will be running the risk not only of starting off a vocational scheme with a doubtful future, but also of obtaining unwilling and hostile submission to the rehabilitation scheme that makes its success problematical. It is, moreover, very likely that the rehabilitated person will, once at work, see to it that he is found unsatisfactory as soon as possible so as to be paid benefit again.

Rehabilitation presumes the voluntary cooperation of the disabled person. If this is absent, then an attempt will have to be made to alter the patient's attitude by persuasion and education. It is not exaggerating things to urge here that the social insurance authorities need to have social workers and psychologists at their disposal. These experts would devote their attention, care and guidance not only to the disabled person himself, but also to his environment and, especially, his family; forces may well be at work within the family circle that encourage the disabled person to settle down to the role of a passive drawer of benefit from whom no further initiative can be asked.

II.2 Activities directed towards making an opening for the disabled person

II.2.1 The business and industrial world is, by definition, run with economics in mind. The value of a man in and to a company is assessed first and foremost by the contribution he makes to production, and by the part he plays in bringing about an excess of income over expenditure.

Seen from this viewpoint, a partially-disabled worker is a low-value worker.Where this involves an employee who, prior to becoming disabled, has for many years made a substantial contribution to the company's results, there will often be a readiness - prompted by feelings of obligation or consciousness of a certain moral duty - to accept the man with his handicap and to make a place for him. But these considerations do not apply to those who had no connexion with the firm before they became disabled, nor do they apply to business that are too small to be able to carry, on their small strength, the liability of a partially-disabled worker of low productive capacity.

Objections are also raised among able-bodied employees to the employment of partially-disabled workers in the firm. The employees, like the management, look on the firm as a means of earning money, and they seek to remove all obstacles to achieving the best possible wages.

Employing one or more partially-disabled workers involves a risk of a drop in the average output per man-hour. If the disabled man is a part of a group whose members' pay depends on the financial results of the whole group, then his presence in the group will be felt as holding them back.

Both employers and employees will have to learn that a firm is more than merely a means of gaining an income, and even more than a means of supplying society with goods and services. The firm is a cooperative community of human beings, in which and through which men are to find full expression, be of service to others and in doing so demonstrate their own value.

The social - or better, the human - function of a business is still far too much an incidental by-product of fulfilling its main, economic function. The social aspects are still conditioned far too much by the economic motive. Social management should, in the overall running of the firm, carry as much weight as the economic management. This is just as necessary, and just as "legitimate", an objective for the firm as trying to achieve an excess of income over costs.

II.2.2 To reinforce the social orientation of management - which is a precondition for reemployment of the disabled in industry that is likely to work satisfactorily - vocational training courses will have to find a place for teaching social techniques as well as giving instruction in technical and commercial skills.

The new trend which seems gradually to be gaining general acceptance in basic and further education - a concentration less on trasnmitting knowledge and more on influencing behaviour - also needs to find a place in specialised vocational training.

We should not think here only of training for management functions : vocational training for the lower ranks, too, should give the students a deeper insight into the needs and possibilities of the firm as a working community of people who are reliant on each other and responsible towards each other.

II.2.3. The attitude towards disabled workers in the firm cannot be divorced from the attitude taken towards handicapped people by society in general. All too often we treat our less able-bodied fellow-men as objects for charity and concern; in doing so we often forget that this solicitude, by seeking to remove all obstacles from his path, is in itself an obstacle to the disabled person's developing himself to the full within the limitations his disablement imposes upon him. Anyone removing obstacles from the disabled person's path is taking away his opportunity of developing in himself the strengths that will enable him to cope with the obstacle unaided. Putting his remaining capabilities to use is not a duty for the disabled person - far more is it a right, to which he has a claim as a human being.

Only in a society where this approach to the disabled is the norm will it be possible to develop attitudes and techniques of human dealing in the business and industrial world which will do justice to the human worth and dignity of the less able-bodied worker, irrespective of and disregarding his productive significance.

II.2.4 What we have just been talking about can perhaps be illustrated most clearly by the way our society treats one particular group of "handicapped" people - the elderly, who are no longer involved in the productive process. This is a group to which we all hope one day to belong. Yet it is a group that is pushed to one side; an object of care and concern, granted - but not one that is appreciated and integrated for the sake of its specific qualities.

This growing group of the elderly holds a valuable store of wisdom and mature experience which we pass over without a second glance. They have served their turn as producers, and so they are put on the scrapheap.

So long as we measure and judge people by what they contribute to the growth of our prosperity, the vocational rehabilitation of the disabled will have to battle on two fronts - on the one hand to overcome the physical and, especially, the psychological resistance of the disabled person himself, and on the other to overcome the barriers in society and the industrial undertaking which prevent the disabled person from being recognized and accepted as a full member of the workforce.

Chapter III PLACEMENT IN PRIVATE INDUSTRY

III.1 Legal provisions

III.1.1 After this general survey of the difficulties that have to be overcome in rehabilitating and reemploying the disabled person, let us now turn to the concrete measures taken in this field.

In the report presented by Mr. A. MARON you have been given an overall picture of the legislation governing the employment of the disabled in private industry or the public services in the Member States. This survey shows that the regulations differ from one country to another within the European Community, as regards both the minimum number of places for the handicapped per firm and the definition of the term "disabled".

Where the obligation to give work to a prescribed percentage of disabled workers is limited to employing handicapped persons who are eligible for disablement benefit from the social insurance scheme, the position has in every case been reached where these places are reserved for persons with a definite handicap. Where this limitation does not apply, many firms will be able to satisfy the legal requirements without taking any special measures - any firm with a staff of any size is bound to have among its employees one or more persons who are no longer able to achieve a 100% output, by reason of some handicap.

Besides this there is still, in countries where employment for registered handicapped workers is required by law, one category of enforceable placing in employment which is excluded - that of the group of self-employed persons who have become disabled, and who were not covered by the social insurance arrangements set up to protect employees.

III.1.2 The widely-differing provisions that have been arrived at seperately in each of the Member States in this matter of placing handicapped persons in employment justify a campaign by the Commission of the European Communities to bring about a harmonization of the regulations on this subject. This harmonization might cover both a description of the group of disabled persons for whom placement in employment might be required by law and a description of the business obliged to provide places, as well as the percentage of disabled persons for whom firms must provide employment.

It is self-evident that, just as is the case in the Member States, the preparation and carrying-out of any Community campaign in this sphere must be taken in hand by the Commission in collaboration with those operating in the welfare field.

III.1.3 Taking on partially-disabled workers sometimes meets resistance if, despite their lower-than-average output, they lay claim to application in full of the working conditions relating to their particular job, as set out in the collective labour agreement. If the nature of their handicap is such that they can do only a part-time job, in which their output per hour is entirely up to normal, then applying the collective labour agreement rules (reduced to match the number of hours worked) should not present any problems.

The difficulties arise when, over a normal working week, their output is less than normal by reason of their handicap. Yet even in cases like this we would argue in favour of paying the normal wage. The disabled worker, who often will have to make a greater physical effort than his able-bodied counterpart and despite this will achieve a lower output, will feel discriminated against if he is paid less than his fellow-workers. So far as he is concerned, he has provided the best output he is capable of. For psychological reasons, to boost his self-confidence and self-respect, he ought to receive the full wage for the function he is fulfilling.

If this cannot reasonably be required of the employer, then it should be made good from social insurance funds. The difference between the wage-value of the worker's output and the full wage laid down under the collective labour agreement should be reimbursed to the employer, thus removing the economic objections to taking on a disabled worker.

I would mention that there is another line of approach that finds support in trade union circles. The handicapped person has acquired certain rights, including the right to benefit, when for reasons of disability he has to accept a loss of earning-power. The right to receive benefit is in no way inferior to his right to a wage. No disabled worker whose output is less than the normal need feel ashamed of having his wage - calculated on the basis of his output - made up by benefits paid by the social insurance scheme; he has earned the benefit just as much as he has earned the wage he is being paid.

This latter thinking will apply in any case to situations where the disabled person is capable only of doing a job which carries a lower wage than the occupation he used to follow before his disablement. Here, a payement of benefit to make up the wage is wholly justified. I myself, however, prefer a system wherby the disabled worker gets the full wage for the job with the "making-up" amount reimbursed to his employer.

III.1.4 Besides the difficulties that arise in connexion with deciding the wage to be paid, employing handicapped persons also presents a special risk of absence through illness. True, this risk can be reduced by making special provision for care at the place of work, but even so the disabled worker will be more susceptible to illness than his able-bodied fellow-workers.

Moreover, he will also in many cases represent a greater risk from the viewpoint of the pension insurance scheme.

So that all the obstacles to placing disabled persons in employment can be removed, it would probably be best for the extra costs to the firm resulting from longer-than-average absences through illness, or through an increased risk especially from the viewpoint of widow's-pension insurance, to be borne by a compensation fund. Such funs, set up for each branch of industry, could be brought under the authorities controlling the social insurance scheme.

III.2 Arrangements inside the firm

Where special arrangements have to be made at or around the workplace in order to place a disabled person in employment, the costs of these arrangements should be borne by the social insurance funds. These arrangements might also include special transport between the worker's home and his place of work, as well as such items as adapting lifts, doors and pathways for employees who can get about only in a wheelchair.

III.3 Final remarks

III.3.1 The legal right of a disabled person to placement in industrial employment should apply also to foreign workers who have legally found jobs in one of the Member States. These workers have to pay contributions to the social insurance scheme, so they have a claim to all the services financed by the revenue from contributions.

Looking ahead to what we shall be saying in the next chapter on sheltered employment, it should be stated here that the foreign worker should have the same right to placement in sheltered employment as the country's own nationals.

III.3.2 Social work in industry needs to concentrate attention on the situation of the disabled worker; the attention will often have to be directed less to the disabled worker himself than to those around him.

Successful reemployment of a handicapped person calls for more than just a full set of legal and financial provisions. He needs to know that he is accepted as a full member of the workforce at his own level. The approach to him in the firm should not be one of pity - on the contrary, he deserves respect and esteem for taking on himself the extra effort needed to make a contribution to production in spite of his handicap.

Everyone needs to be in an environment which is well-disposed towards him if he is to enjoy his work. This is especially true of the handicapped, who realise that their inclusion in the production process will often make extra demands, in respect of collaboration and concern, on their fellow-workers.

III.3.3 As well as the special adaptation of and around his workplace, the disabled person also needs extra arrangements in his everyday life. Modifications to his dwelling can in a number of cases already be paid for from social insurance funds. The same is true of special transport arrangements, even when these are not connected with his journeys to and from work.

The recreation facilities available to the disabled are quite definitely insufficient. The amount of suitable holiday accomodation for the handicapped is completely inadequate.

When, in the Member States, there is talk of the staggering of holidays, this is done over a short period of six, and at the most eight, weeks. This means that disabled workers have to take their holidays in the high season, when both public transport and accomodation in holiday centres are loaded beyond capacity.

It might be worth inviting the Commission of the European Communities to study the possibilities of arriving at a better-adjusted staggering of holidays between the Member States, with an eye specifically to the desirability of disabled workers taking their holidays outside the peak weeks of the high season.

Chapter IV PLACEMENT IN SHELTERED EMPLOYMENT

IV.1 General aspects

IV.1.1 A large proportion of the disabled will, despite the best of special arrangements and adaptation, be unable to find a place in private industry, so there needs to be, as a "long-step", a system of sheltered employment available for those who have no prospects of ever finding a job in ordinary industry.

Although the setting-up, running and financing of suitable employment is a task for the authorities, their partners in the welfare organizations need to be fully involved in it as well.

Care of the handicapped is a responsibility of society at large; seeing to their employment is the task of industrial society. Both employers and employees should, through their organizations, not strive merely to achieve full employment for able-bodied workers - unemployment among disabled persons who are capable of working is just as much their concern.

IV.1.2 This means that sheltered employment must be reserved for those who are handicapped in body or mind, or both, and who still have skills remaining which can be put to productive use but which they cannot put into practice in open industry.

A sheltered workshop is intended for these people, and for them alone. It is their business, tailored to their needs, and directed towards making the best possible use of their capacities.

The trade union movement feels that it is basically unjust to make use of this employment opening as a reception centre for the older unemployed who solely because of their age have scant prospects of finding employment in private industry. Giving employment to unemployed persons whose only handicap is their age, and who are otherwise capable of doing a full job of work, in an establishment for specially adapted work leads inevitably to the seriously-disabled (for whom this employment opportunity is intended) becoming demoted to second-class workers in their own business. Their output will always fall short of that of the older, able-bodied employees. Still less can sheltered employment be used as an institute for getting the workshy and maladjusted used to the idea of working. Every society has people who are more lazy than tired - people who make a sport of enjoying as much unemployment benefit as possible for as long as possible, and who see an opportunity for dodging every offer of suitable work and who, once put in a job, make sure by their behaviour that within a few days they get the sack so that they can draw the dole again.

The employment exchanges are then soon tempted to send these workshy people into sheltered industry. The fact that once there they will poison the working atmosphere by their behaviour and obstructiveness is then looked on as something that has to be put up with.

We believe that disabled workers in particular cannot face such an extra burden in their working environment, and that we cannot thrust it on them. This is why the trade union movement urges very strongly that sheltered industry should be open exclusively to disabled persons who cannot hope to return to work in private industry because of their low productive capacity.

IV.1.3 Employment for the disabled is specially sensitive to the economic climate. When the labour market is fully stretched, private industry will take steps to keep, or attract, even disabled workers. Recruits to sheltered employment will then be those with hardly any productive capacity at all.

At the same time industry will, in a boom period, try to contract-out as much work as possible to the sheltered workshops. Sometimes even machines and supervisors are provided for the sheltered workshop, so as to take the strain off a private firm's own production capacity as much as possible. The situation that then results is that the sheltered industry has a low-grade work-force coinciding with a well-filled orderbook.

If there is a recession, many private firms will start the cutting-back that is necessary by laying-off its less able-bodied workers. These return to sheltered industry, where the labour force will often swell quite substantially as a result. At the same time, the firm takes back a large proportion of the orders to sheltered workshops for completion in its own works, so as to keep its own workpeople in employment as long as possible. Thus, an increase in the number of workers in sheltered industry is accompanied by a shortage of work for them to do. In this way, the disabled workers form the first buffer that has to bear the brunt of a recession.

IV.1.4 It is clear from this that the task of the authorities cannot be limited to setting-up and running sheltered workshops, leaving the industrial and business world responsible for providing an adequate supply of work. The authorities themselves must take an active part in ensuring a continuous flow of orders that will be unaffected by the economic climate.

Anyone pursuing a policy based on the idea that the disabled, too, have the right to work must also see to it that there is enough work to do should the industrial world be unable to send the sheltered workshop a sufficient number of orders.

IV.1.5 Here one might offer a comment on work methods. There can be a tendency, in order to find work for as many handicapped people as possible, to aim for labour-intensive production methods. Anything that can be made by hand, no matter how time-consuming this may be, is preferred to a production using labour-saving machinery. Mechanization in sheltered industry often lags behind that in private firms. But if this line is taken, productive work runs the risk of becoming instead just a means of keeping people busy.

We think this policy is wrong: modern work methods and techniques should be applied in workshops for the disabled, too - though, of course, adapted to the capabilities of the employees. Only in this way can we foster the handicapped person's realization that he really is making a valid contribution to the general prosperity of the community.

IV.2 Welfare provisions

IV.2.1 The argument has, of course, been put forward that the level of wages in sheltered industry should be lower than in private industry, so as to stimulate the disabled to carry on looking for employment in an ordinary firm. For those whose handicap means that they will never be able to cope with work in private industry, however, this represents a penalty being imposed because of their disablement.

The sheltered workshop ought to pay the normal wage for the type of work carried on there. It would then be a social rehabilitation for the disabled worker when he can go back to working with a private firm, even though financially this may not mean any improvement.

IV.2.2 The "secondary" work conditions, too, must bear comparisons with those in ordinary industrial life. This includes hours of work. As a general principle these should be the same as in private industry, although allowances will have to be made for the often considerable distances between the worker's home and the place where the sheltered workshop has been set up.

In cases where severely handicapped persons can work only part-time, the wage will obviously be matched to the number of hours worked; the discrepancy will then have to be made up by benefit from the disablement insurance funds.

IV.2.3 The work conditions in sheltered workshops should be arrived at in consultation with the trade unions. The disabled, too, have a right to social participation; they can dispense with the protection provided by a trade union championing their interests even less than can able-bodied workers.

IV.2.4 They lack the opportunity of looking for a job elsewhere should they not be in agreement with the work provided or the work conditions applied. The sheltered workshop is their last chance, and beyond it there is only the yawning emptiness of unemployment.

Special attention needs to be paid to their right to a voice in their own affairs. This is a far from simple matter. The handicapped often tend to hold society responsible for their disability, and this leads them to feel that they are justified in making what are often unreasonable demands. This situation calls for a great deal of wisdom and patience on the part of the management in sheltered industry, and frank and honest labour negotiations in a sheltered workshop will often need more time and greater persuasive powers than usual. But this time spent is not lost; the experience of being able to have a say in these discussions will bring a positive strengthening of work-motivation, and thus contribute to a sensible level of production.

IV.2.5 It will often happen that the employees in a sheltered workshop include some who are entitled to benefit from the social insurance scheme, and others, e.g. previously self-employed persons who have become disabled, who are not.

This difference in entitlement to benefit should not affect the level of wages arrived at for these workers. From the social viewpoint it is far better to pay the full wage in every case, so that benefit (including supplementary benefit) can be discontinued. Only in this way will the disabled person get the feeling that he is actually able to earn his own living by his work.

IV.2.6 Special thought should be given to the policy that decides where, over the various regions of a country, sheltered industries are to be set up. On the one hand there is the desirability of establishing these workshops in areas of high employment, since this will give the greatest chance of their being operated on sound economic lines. In industrially backward regions it is time and again found extremely difficult to attract enough work contracts to keep a sheltered workshop going.

On the other hand, it is precisely in areas where there is a low level of employment that there will be, relatively, the highest number of disabled workers wanting sheltered employment. If it is thought socially desirable for sheltered workshops to be set up in these high-unemployment areas, then there must be a guarantee of a sufficient flow of orders (e.g. from the public authorities).

Chapter V THE POLICY OF THE EUROPEAN COMMUNITIES

V.1 There is an obvious connexion between the medical and financial provisions in the framework of social security and the possibilities of developing opportunities of employment for the disabled. The programme of the European Communities aimed at harmonizing social security should cover not only the bringing into line of the entitlements to benefit in the Member States, but also the policy of these countries with regard to suitable opportunities for employment.

Social security is more than just a right to financial benefit - it includes the right to work. A study of legislation on the vocational rehabilitation and placement of the disabled, such as we have been making during this symposium, will have sense and purpose only if it leads to a decision by the General Directorate on Social Affairs to take the harmonization of this legislation in hand.

V.2 There are, however, also points of contact with policy on the labour market as a whole. The migration of workers from areas of chronic and inherent unemployment to areas of full employment is out of the question where the disabled are concerned. They are, more than they ever were before, tied to one spot. So it is worth considering wether and to what extent Community funds should be able to make a contribution towards setting-up and operating sheltered workshops in areas of chronic unemployment, as part and parcel of the Community's labour-market policies.

In this context we would like to take the liberty of making a comment that does not, directly, have anything to do with the reemployment of the disabled. However low one sets the standards for residual working capacity in disabled workers for whom reemployment is to be found,there will always be a category of people who cannot meet even minimum standards of productive work: we have in mind, for instance, those who are spastics, epileptics and so on.

For these severely-handicapped persons, who at present largely live out an empty life in day-centres and special-care establishments, there is a need for experimental activity-centres where, besides following a modest course of vocational training, they can also take a part in programmes designed to improve their social integration.

Contributions from Community funds to finance these experimental centres seem to us to be well-justified and in keeping with the social objectives of the European Communities. Even handicapped people who are unable to make any further productive use of their capabilities have a claim to the fullest possible development of their very limited potential. At the same time as we are making greater efforts on behalf of those who can match these efforts with a contribution of their own to the general prosperity, we ought also to pay greater heed to the group of handicapped persons who are incapable of making even this modest contribution.

V.3 It has surely become clear, in the course of this symposium, that the rehabilitation and reemployment of the disabled calls for a great deal of medical and vocational-guidance skill, as well as for the establishment and upkeep of expensive rehabilitation facilities. Even after completing a course of rehabilitation, many of the disabled will need guidance and aftercare for a long time to come.

Thought should be given to drawing up an inventory of what opportunities and facilities are available in this field in the Member States, and thus finding out wether the available provisions are adequate to meeting the existing vocational rehabilitation needs. A study should also be made of wether the results of rehabilitation cannot be improved by collaboration between the various bodies, including the specialized agencies, within the Community.

We do not look upon ourselves as competent to act in this sphere - other than by asking these questions, which we may hope is no more than pushing at an open door.

V.4 We have, a number of times in this report, already referred to the need for involving the welfare organizations in the work of finding employment for the disabled, even when this takes place via arrangements financed directly by the government.

The organised industrial and business world, too, should be brought in if the Commission of the European Communities is going to undertake initiatives in this field. The responsibility of the industrial and business community towards these weakest of the weak must find a place in the policy followed by the Community.

To conclude: efforts directed towards bettering the living and working conditions of the disabled cannot be confined to the making of financial and welfare provisions alone, nor to improvements in medical care. Public opinion, too, needs to be worked on. All too often, care for our disabled fellow-men stops at appeals to charity and a trading on sympathy. There must be a growing awareness that the disabled person has a right to fulfilment within his capabilities, and that it is society's duty to honour this right.

If it is true that the number of handicapped people resulting from road accidents is already several times higher than the number of disabled we have among us as a legacy of the Second World War, then it follows that the care of the disabled is going to make an ever-increasing call on our finances, our expertise and our time.

Let us hope that this symposium may help towards growing recognition that the right to a meaningful human life for those who cannot achieve it on their own includes the right of the disabled to work. Their rights are our duties.

Dr. BASTENIER

1. The work of the industrial doctor in the placement of disabled persons

1.1 How the industrial doctor's role has developed

The collaboration of the medical profession with the activity of industrial undertaking has a history of less than a century, and yet during this time the duties of the doctor have undergone constant change.

Originally the doctor was called upon to deal with accidents at work; he provided medical care in surgeries and examined accident victims with a view to their return to work. Employers availed themselves of his services to check that absences from work were justified and to reveal and then control absenteeism which was not due to genuine sickness. Legislation was introduced imposing on the doctor the additional duties of tuberculosis prevention and medical examinations of adolescents. Between 1920 and 1940, the medical examination of workers was extended to categories other than adolescents, first of all to particularly exposed workers and eventually, in some Community countries, to all workers.

The medical examination on engagement was introduced to block the way to persons of unsound health so as to guarantee the employer normal productivity and low absenteeism.

However, the effect of this policy of selection was systematically to bar from all jobs a large proportion of candidates having an identifiable deficiency which was not necessarily incompatible with the exercise of an occupation.

Serious criticisms began to be levelled at this selection policy and a new trend developed, whereby the industrial doctor was called upon not to reject anyone but instead to endeavour to occupy all persons, in spite of their deficiencies, on jobs within their capabilities.

In this way there came into being what amounted to a policy of employment for all, which was formulated in a recommendation of the European Economic Community, which defines the duties of the industrial medical service as follows; these duties are also included in the General Regulation on the Protection of Labour (Article 104) in the following terms:

1. Monitoring workers' state of health and informing and advising them as to any diseases or deficiencies from which they might be suffering;
2. Drawing the attention of adolescents to their physical and mental aptitudes for the purposes of vocational guidance;
3. Preventing the appointment of workers to jobs whose difficulties they would be unable to tolerate normally by virtue of their state of health, and the engagement of persons suffering from disorders which might present a serious risk of contagion or a safety hazard to their workmates in the workshop or office;
4. Contributing as far as possible to the adaptation of workers to their jobs and to the adaptation of operations to the facts of human physiology;
5. In principle, the non-rejection of anyone from all works, but instead, where possible, the occupation of all persons, in spite of their deficiencies, on tasks within their capabilities;
6. As early detection as possible of occupational diseases, immediately on the appearance of the first symptoms;
7. Keeping watch over the conditions of hygiene of the job and over all other factors which might affect the health of the workers;
8. Co-operating continuously with the management and the various departments of the firm, and with the representatives of the firm and of its staff, in

order as effectively as possible to prevent occupational diseases and working accidents;

9. The provision of immediate first aid and emergency care, as stipulated in Articles 174 to 183 of the present Regulation, to workers who suffer accidents or fall ill, unless other medical services, mentioned in Article 182 thereof, are responsible for such aid and care.

Investigating the causes of absence was found to be incompatible with the possibility of becoming and remaining an adviser to the employer and the workers. The industrial doctor was therefore rightly relieved of this duty, which is now the province of others.

1.2 The role of the industrial doctor in the placement of the disabled

The law provides that one of the duties of the works doctor is to assist with the placement of disabled persons. Only the doctor can understand the extent of the disablement and assume responsibility, on an informed basis, for allocating a specific job to a disabled person, secure recognition of the fact that certain jobs are incompatible with sufferers from particular illnesses, and assert that the performance of a given task by a disabled person does not constitute a danger either to himself or to his workmates.

With other members of the firm, such as the production manager, the personnel manager, and sometimes the industrial psychologist and social worker, the industrial doctor can contribute to the adaptation of a disabled person to his job or, as is frequently the case, to the adaptation of the working conditions to the abilities of the disabled worker.

The industrial doctor protects the interests and health of the disabled worker, and at the same time he guarantees to the employer that disabled workers are not appointed to jobs which they are incapable of performing.

The industrial doctor has a part to play in securing recognition that workers with those deficiencies he is familiar are disabled persons, since he is responsible for everyone's health and is in a position to give advice.

Again, the industrial doctor is the man in the best position to study, in the working positions, the action of environmental or working factors liable to affect the health of a person suffering from a given deficiency.

Whether by himself or in a team, in a firm or in an organisation providing services for a number of firms, the industrial doctor is therefore bound to take a part in the process of placing disabled workers in jobs.

2. The contribution of the industrial doctor to placement today

My experience in the day-to-day running of an industrial medical service with a total membership of over 1400 firms employing a total of over 50.000 workers has given me an insight into the way in which disabled persons are placed in jobs today at firm level in Belgium.

This experience constitutes the foundation of my present theme, which is purely personal and applies only to Belgium. However, the situation would not appear to be fundamentally different in the other Community countries.

If there are any important differences, this conference will provide an opportunity for correction to my comments.

2.1 Legal foundations for the action of the industrial doctor

The legal foundations of the role of the industrial doctor have undergone considerable development before reaching their present form. However, the role defined thereby remains general in scope.

The role of the industrial doctor is little known in industrial circles and one finds that the general principles set out in the relevant law are frequently disregarded.

In most firms which are willing to apply the legislation, only the duties specifically prescribed in the law are in fact performed, i.e., most frequently, medical examinations of workers. The other jobs of the industrial doctor are passed over or reduced to their simplest form of expression. This is the case with the placement of the disabled.

Belgium has passed a law on the social resettlement of the disabled. However, at firm level, whilst the principle of an obligation to employ disabled persons in enshrined in a legal text, no compulsory percentage of disabled workers has as yet been laid down. True, it is stated that this percentage will be fixed at a later date. But at present, the stipulation of a compulsory percentage is still outstanding.

The industrial doctor himself wonders who qualifies as a "disabled person".

According to the situation as between the worker and the firm, the industrial doctor distinguishes between the following:

1. Disabled persons registered as such by an official resettlement body;

2. Unregistered disabled persons.

The second group are by far the most numerous at firm level. This group may be subdivided as follows:

"Internal" disabled persons, attached to the firm at the time of commencement of the disablement;

"External" disabled persons, not on the staff, who apply for jobs.

According to the type of handicap, the industrial doctor distinguishes:

1) Persons with mental disabilities, either with deficient intelligence or with personality disorders;
2) Persons with physical disabilities due to disorders of the locomotor system;
3) Persons with organic disabilities due to functional disorders (cardio-vascular or respiratory), metabolic disorders (e.g. diabetes) or chronic sickness (e.g. rheumatism).

For the industrial doctor, placement will depend on the status of the disabled worker and the nature of his disability.

The legal texts seem mostly to ignore the organically disabled and deal only with persons suffering from mental or physical disabilities.

At job level, the resettlement of the three categories raises very different problems, and different policies are needed for the placement of the persons concerned.

2.2 Employer reactions

Daily contact with employers and managers shows that management is largely ignorant of the progress made by modern industrial medicine. This is particularly evident in connection with industrial medical services, two-thirds of whose members have a labour force of less than 50.

In general, the employer knows that certain obligations result from accidents at work, and that certain occupational disease risks entail an obligation to perform medical examinations, but he is completely ignorant of all the other aspects of the work of the industrial doctor. He issues orders to see that the requirements of the law are observed, but in most cases has not himself personally read the legal text. He is extremely intolerant of hygiene inspections of the work place and takes offence at the slightest criticism of his workshops; he does not hesitate to terminate his membership of an industrial medical service which tells him that he is breaking the regulations and should modify his installations or techniques. He justifies himself in his own eyes by saying that these hygiene inspections merely increase his costs and that workers' medical examinations are already expensive enough.

The employer knows little about ergonomics and refuses to contemplate the adaptation of workers to their jobs and the adaptation of working operations to the facts of human physiology. He claims that these problems do not arise in his firm and that in any case the workers do not make any complaints; in the circumstances, he prefers not to raise the problem.

In some large firms, when the economy is booming, the management is prepared to trust the industrial doctor and tolerate his discussion of these problems of adaptation with executives or members of the safety and hygiene committee.

However, even in firms which consider themselves up-to-date, the management cannot avoid considering the activities of the industrial doctor as anything other than an expense. Employers are unconvinced of the benefit of an ergonomic job organisation.

As to the employment of disabled persons, they are afraid that this will raise new problems when they have quite enough already.

Employers make a sharp distinction between "internal" and other disabled persons. As a rule, as far as possible, they are prepared to contemplate a humane solution within the firm for workers who become disabled after having been on the staff for a long time. But they have no wish to engage "external" disabled persons and fear the red tape accompanying the engagement of disabled persons registered at a resettlement office (Fonds de Reclassement). In any case, the social resettlement law is not very well known to employers. With very rare exceptions, employers have no set policies as to the employment of disabled persons. If they agree to take on a disabled person, this is generally to do someone a favour or as an exceptional gesture in an unfortunate case which has been brought to their attention. Employers are loth to raise the problem of their own accord.

2.3 Workers' reactions

The trade unions are perfectly aware of the importance of an employment policy and are as a rule opposed to the idea of selection, so as to give everyone a chance of finding a job.

However, at firm level, the industrial doctor often finds that there is a sort of competition to secure the "easy" jobs. In this competition, it cannot be claimed that the fit always give way to the disabled.

Workers are often reluctant to accept a disabled person in a team. Although they do not say so in as many words when asked, it seems that they fear a lowering of output and hence reduced bonuses. They also claim that in most cases they will have to do part of his work for him. It is by no means unusual for the disabled worker to be received badly by his companions, who do not always realise the harm that certain remarks can do.

The industrial doctor who attends meetings of the Safety and Hygiene Committee finds that the problem of the disabled is never on the agenda, and that the workers' delegation never makes any proposals on this subject except as regards "internal" disabled persons. For these, the workers' delegations do, in fact, often intercede effectively. In the case of "external" disabled persons, however, there is a sort of tacit agreement not to raise the problem.

The registered disabled are never even mentioned.

As in the case of the employers, the workers, too, seem to have no set policy as regards the employment of the disabled. In both cases, there is a lack of information which cripples every initiative in favour of the rational placement of disabled persons, especially in small firms.

3. Rational organisation of the industrial doctor's contribution to the placement of the disabled

3.1 Establishment of a social resettlement policy

From the point of view of view of the industrial doctor, it is obvious that participation in the placement of workers with physical, organic or mental handicaps falls within the province of his work. However, this does not appear so obvious in the boardroom and on the shop floor.

It is time to get yway from continuous improvisation and to establish at firm level a policy for the social resettlement of the disabled.

The industrial doctor wishes the employer to indicate clearly his intentions and the limits of his willingness to engage disabled workers for specific jobs. This is particularly important where the doctor belongs to an industrial medical service, where policies may vary from employer to employer.

The work of the industrial doctor with managements would have a firmer foundation if the legislator would clarify his intentions and spell out precise obligations. Experience shows that merely to state general principles spurs very few people to take action.

There should be clear statements of policy in regard to the placement of disabled workers on the following points:

1) The placement of disabled persons requires co-ordination between the various interested parties. A co-ordinating body should be set up at firm level and specific appointments made, carrying the necessary powers to deal with actual cases.
2) The jobs which can be filled by disabled workers should be located. The requirements of the job and the associated environmental hazards should be studied in collaboration with the industrial doctor. Some of these jobs should be reserved for the disabled.
3) The priorities to be granted to the different categories of disabled workers should be defined. It is understandable for employers to accord priority to former employees who have suffered an accident or illness, but this legitimate priority should not be totally exclusive. A specified proportion of the reserved jobs should be open to "external" unregistered disabled persons and to registered disabled persons.

3.2 Participation of the industrial doctor in the placement process

3.2.1 During the rehabilitation process, the industrial doctor should be kept informed of the progress of occupational rehabilitation. Otherwise, now that the industrial doctor no longer provides treatment or checks on absences, he will not learn the true condition of the worker until he returns to work.

Workers who are unable to resume their old jobs are retrained in another field, but as a rule without any prior study with the doctor of the precise conditions for this re-orientation. The new job seldom corresponds to the vocational preparation received by the worker in the rehabilitation unit. Indeed, it is not infrequent for the patient simply to return to the factory when his medical practitioner gives the word. In such a case, he is faced all of a sudden with the requirements of production, and it is hardly surprising if the resumption of work turns out to be a failure.

The industrial doctor should be associated with the preparation of an unregistered disabled person's return to work. Similarly, before the engagement of a registered disabled person, the industrial doctor should be associated with the concluding stages in his preparation and with the choice of job.

Through his familiarity with the job which the worker will take, the doctor would be able to direct the rehabilitation accordingly and suit the occupational training to the job. If he knows the capabilities of the candidate during rehabilitation, the industrial doctor could adapt the job to suit his personality.

Collaboration of this kinds is much easier in the case of firms having a rehabilitation workshop, where functional re-education, occupational training and rehabilitation to working conditions proceed side by side under the supervision of the industrial doctor. However, this very effective institution is found only in very large firms.

3.2.2 Particular attention should be devoted by the industrial doctor to the stage of returning the subject to work at the normal pace of production. The doctor should have prepared the working position in collaboration with the senior staff. He should talk to the person's immediate superior and his workmates so as to prepare them for the advent of the newcomer and to accept him in their midst.

Failures in returning disabled persons to work are due as much to the psychological conditions of the re-introduction of the subject into the social milieu as to occupational inability to perform the work.

3.2.3 Medical supervision of the disabled person in the early stages of the full resumption of work is extremely important.

The industrial doctor should be allowed to conduct this supervision as he sees fit. He should be able to examine the worker whenever he considers it necessary in order to ensure that his adaptation to the job is proceeding properly.

This supervision is particularly necessary in the case of persons with organic disabilities.

A large volume of scientific research has established the conditions under which persons with particular disabilities can resume work, e.g. tuberculosis and heart sufferers. However, the resumption of work can take place without harm and without aggravating the condition only if the worker is under the supervision of the doctor, who can detect signs of lack of adaptation and can act in time to correct the situation.

Relations with the rehabilitation doctor or the medical practitioner should be maintained, in order to permit more comprehensive examinations so as to verify whether the patient is adapting well or whether his health is deteriorating.

The initiative for these contacts should be left to the industrial doctor.

3.2.4 The failure of an attempt to return a disabled person to work should not entail complete regression of such qualification as he has been able to acquire.

To avoid this regression, even in the case of a failure, the industrial doctor should be able to keep the disabled worker in a "waiting" job. He should not be obliged to turn him away in favour of other applicants.

For the disabled person, every failure is experienced as a serious setback likely to sweep away any inclination to achieve resettlement for a very long period.

A possible solution would be a temporary return to the rehabilitation section, if the firm has one.

Another answer would be temporary placement in a sheltered workshop in a waiting situation, without losing the benefit of the patient's preparation.

Sheltered workshops lend themselves better than normal production lines to adaptation to suit all disabilities without extensive preparation. They have the co-operation of trained instructors and are not obliged to achieve a fixed output.

For this reason, the industrial doctor, especially in industrial medical services, should be able to make contact and remain continuously in touch with sheltered workshops, and should have the right to transfer to them on a temporary basis any disabled worker who cannot adapt to the proposed job.

The social resettlement of the disabled demands enduring patience from all concerned. Like the other parties involved, the industrial doctor contributing to the placement of a disabled person should have the opportunity to make a fresh start in the case of a failure, without this being to the detriment of the disabled person concerned.

Dr. GODARD

In the socio-economic context of our Western European countries, the resettlement of workers disabled by illness or accident is one of the most difficult duties facing the works doctor, whatever his status and powers in the company.

This at least is my experience after twenty-five years in industrial medicine and after comparing my views with those of my colleagues in other Community countries.

Because of his position at the boundary between man and machine, confronted daily with concrete facts rather than statements of principle, the works doctor is perhaps able to see more clearly than most the ambiguities or even contradictions in the attitudes adopted by various people to his problem. Successful resettlement demands the convergence - which is rarely perfect - of the aims pursued by those involved in this complex and difficult task. Although these subjects have already been extensively discussed, allow me to revert to them and speak frankly for a few moments. We shall in any case consider the subject more particularly from the viewpoint of the company doctor in a large work rather than that of the doctor in an inter-firm service, an aspect covered by Prof. BASTENIER.

For the person involved, who is called the victim, which etymologically is said by some to mean "the vanquished one", the main problem, whatever one may say, is that of the standard of living, especially when the patient occupied a well-paid job before his disability. Neither he nor his family can easily accept a more or less considerable drop in income, which is the all too frequent consequence of his assignment to a new job better suited to his disability, since social legislation, however far advanced, only offers compensation in certain cases and it is never equivalent to the damage suffered. It is impossible to emphasise too strongly that a drop in pay for a disabled person has above all the psychologically catastrophic implication of a depreciation of his person, both in his own eyes and in the view of society.

There are two paths open to him: either by an often considerable effort of will and courage to try to overcompensate in his job in order to overcome his disability, or to follow up all the ways and means of securing what he considers to be due to him as fair compensation for his injury, i.e. a pension. Hence those forms, often described too complacently and exaggeratedly, of protest manifestations known as malingering, "pensionitis", occupational neurosis, which are more or less conscious and, from the point of view of the disabled person, more or less justified. The attitude of the trade unions reflects to varying degrees the ambiguity of these attitudes.

On the part of the employer, apart from more or less seriously affirmed philanthropic considerations, the general tendency is, for reasons of productivity, to require everyone to do normal or average work in the job to which he is assigned. This attitude is justified by the constantly increasing costs of industrial investment per worker, and by the continuing increase in social security costs appertaining to the labour contract. This is the reason for the frequent reservations regarding the employment of disabled persons, since it is feared that their output will be too low, and for the refusal jointly to seek ways of adapting the man and the job to each other, which would often provide a happy solution.

These reservations are also found in society and find expression at the level of the government, local authorities, or private bodies having financial responsibility for the system. Humanly speaking, it is certainly almost unanimously recognised that lack of occupation is harmful to the psycho-physiological equilibrium of the disabled worker and that granting him a pension enabling him to subsist is far from solving all his problems. But in a society in which profit is one of the fundamental ethical values with the inevitable consequence - except in a temporary period of full employment - of a reserve of industrial manpower composed of more or less able-bodied unemployed, is it possible to secure the establishment and adequate financing of suitable structures to restore workers disabled by illness or accident to the labour market with full opportunities, thus swelling the ranks of those seeking employment? This is a dichotomy which has not been resolved and it would be hypocritical to close our eyes to it.

I would add that, for the works doctor, the resettlement of the seriously disabled - as referred to throughout this colloquium - however painful it may be, is only one, and by no means the most frequent, aspect of the general problem of the job changes that are required each year with growing frequency. This general phenomenon is linked to the accelerated pace of technological progress, the great transformation in human labour which is taking place before our eyes without perhaps receiving sufficient attention and whose main consequence is that muscle power is becoming less and less important while psycho-sensory skills are becoming predominant. Hence the growing unemployability of many lower-class workers, whose powers of adaptability are exceeded, or even diminish as the technological requirements increase. What can we say about all these workers, aged before their time, difficult to pigeonhole medically, worn out, as much by a life of toil as by miserable living conditions and harmful health habits, which too often include the immoderate consumption of alcohol. To retrain workers is all very well, but they must be retrainable. I am convinced that the resettlement of such persons and their optimum use, are already and will be increasingly major employment problems in the industrial society.

Although this is not the subject of the present colloquium, I feel it necessary to draw the attention of the audience to this point.

Having said this, the experience acquired by the practitioner of industrial medicine leads him to a number of essential conclusions that are most probably not original but that we think should be put before you. After this it will only remain to describe the specific role that the works doctor can play.

Our main comments can be expressed in ten points:

1. In the process of resettling and re-establishing the disabled person, the main difficulty lies not so much in the severity and extent of the physical or even mental handicap, but in the intelligence and social class of the patient, as it is at this level that his powers of adaptability lie. The medico-socio-psychological team to which I belong is at present dealing with the case of a young worker of North African origin, otherwise in good health, who has had his right arm amputated at the shoulder joint as a result of a serious accident. In our industry, there are many machine operatives' jobs that can be filled with this disability. However, in these jobs it is necessary to be able to read and interpret some instructions, perform simple arithmetic (addition and subtraction) etc. On the basis of a psychological examination prior to the accident, it appeared to one of us that this man was of a higher level than the average for his group. However, after one year of education, he still cannot subtract without error and experiences serious difficulties in carrying

out instructions which appear to us quite elementary. We have reached an impasse.

2. In this context age does not appear to us to be as important as it is often thought to be. There is no age limit for rehabilitation; even though the powers of adaptation appear in general to diminish gradually with age, the obstacle often in fact lies elsewhere.

3. Likewise, the profound motivation of the subject towards the re-establishment of his person and of his skills is of considerable importance. In this respect a positive attitude by the medico-psychological and social teams that take charge of the treatment from the start is of great importance for the future behaviour of the disabled person. Obviously specialised treatment centres for functional rehabilitation and vocational retraining give the best results.

4. For the purposes of this colloquium, which is mainly concerned with seriously disabled adults who have previously worked, we consider that functional rehabilitation starting as early as possible and being as extensive as possible, and where appropriate the quick provision of a functional prosthesis, are far more important than apprenticeship to a new trade, which is always difficult to learn and the demand for which is uncertain. Moreover, in a large company a disabled person who was formerly on the payroll can almost always be re-employed; it is the employment of a disabled person from somewhere else that meets with objections.

5. Resettlement will also be facilitated if the subject can find a job in his former industry, as otherwise the difficulties of fitting into a different occupational and geographical environment are added to the strain of changing jobs. Consequently large industrial undertakings generally offer more numerous possibilities than small

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firms, even though sometimes great success can be achieved in the latter through the good will of the employer and his concern for his employees.

6. Resettlement is easier in some industries than others,and that is why studies relating to these problems mainly concern office jobs, light engineering or electricity. On the other hand, heavy industry such as iron and steel, mining and the building trade, raises difficult problems.

7. The social and occupational resettlement of the disabled person depends not only on him but also on the environment in which he will be placed; if he is surrounded by understanding and co-operative foremen and fellow-workers, success is likely. If he encounters indifference or ill-will, failure is almost certain. It is at this very important level of the workshop that the contribution made by the line management of the firm and shop stewards appears vital. Any job is complex and often requires certain rare or exceptional operations that are impossible or almost impossible to carry out with the person's handicap. A categorical rejection will too often be made unthinkingly when an effort at understanding, a slight modification to the equipment at the work place, to the distribution of tasks or to the instructions given would almost always enable the difficulty to be overcome. It is still necessary to obtain the consent of foremen and fellow-workers. Experience shows that provided the importance of the matter and the moral and material benefit to be derived by the disabled person are explained to them, the appeal to workers' solidarity will not be in vain. The foreman and shop steward have a vital influence in this respect.

8. Resettlement will be easier if the legal and administrative structures, whatever their nature, even if they make only a minor but known contribution, play a full

and harmonious part. In this respect, much progress remains to be made and the status of the disabled person must be clarified.

In the meantime, nothing is more discouraging and irritating than these procedures, checks, expert opinions, deadlines and joint decisions that all too often impede the always arduous progress of the disabled person towards a new physical, occupational and social status in which he can once again feel that he is a full citizen and worker.

All too often he needs exceptional merit to overcome all these obstacles and to refuse to accept, as unfortunately do all too many, the status of a person on public assistance.

9. Resettlement will be all the easier if it derives from a continuous programme of action started as soon as the handicap occurs. Since others have done so, it is unnecessary to stress the need for a plan prepared with the assistance of the various specialists who guide and support the disabled person during the various stages. In this respect, the role of the works doctor is important, but he feels that he cannot act alone. To forget him would be a mistake. To give him an almost exclusive role would be another.

10. Finally, although experience shows that resettlement among so-called "normal" workers can, subject to certain adaptations, be obtained in a very large number of cases, the establishment of specialised public or private work units is essential for some disabled, mainly in the form of temporary or permanent sheltered workshops.

It remains for us to clarify - in this very complex situation and amid all these often diverging and sometimes even contradictory data - the role of the works doctor in the teams responsible for resettlement of the disabled.

The works doctor - and I specify again that it is mainly the company doctor who is concerned here - is the only one, except in some cases the industrial psychologist, who is part of the company.

He therefore knew the person before the handicap occurred. He also knows the work places in the company; that is his job.

Although in practice it must be admitted that these statements are not always unreservedly true, the fact remains that it is his continuous contact with the working environment that gives the works doctor pride of place and enables him to be involved in all stages of retraining and resettlement. Let us clarify these points with further details:

1. The preventive role. This should not be forgotten. The problem of the disabled in our industrial society starts with prevention. For the works doctor, there are two aspects, safety and first aid.

We shall not dwell on the former, which would take us too far from our subject, but the latter should be considered more attentively: everyone knows the importance of the first few minutes following the accident and the serious repercussions or even catastrophes caused by incorrect handling at that time. Surgeons deplore the incompetence and sheer clumsiness of the public or insufficiently qualified pseudo-first aid workers. The training of experienced first aid workers and the provision of constant practice is one of the important duties of the works doctor: if the whole labour force cannot be trained in first aid, which would obviously be desirable but difficult to implement everywhere, I would recommend the following system that I had adopted by the management of my works more than 15 years ago; any worker promoted to foreman must either already be trained in first aid or must undertake to take a course in first aid within six months of his promotion; the foremen, together with voluntary first aid workers, form a protective team able to give first aid on the shop floor on a very satisfactory basis.

It goes without saying that the works doctor acts in person, where necessary, to give first aid. Experience shows that this action is often useless; as the golden rule is speed, the principle to be followed is "from the first aid worker (or nurse) to the operating table as quickly as possible", and the intermediate stage of examination by a doctor runs the risk of wasting precious time without any real advantage to the injured person.

2. Personnel medical records. These contain information on the physical capabilities and pathological history of the persons concerned, some details of which may be useful to the teams, especially when the rehabilitation plan is prepared. Any exchange of information in the interests of the patient is therefore highly recommended.

3. Job studies. These are very widespread in industry, but from many different aspects: job evaluation, ergonomics, safety, etc. The works doctor should normally participate in such studies. It is worth emphasising that he can do so with the intention, amongst other things, of pinpointing in the company jobs that are compatible with certain physical, psycho-sensory and psychomotor disabilities. A study made from this aspect is very instructive. This can be demonstrated by the survey we undertook a long time ago in a steelworks, which will be described briefly.

We found, together with the management of our works, that as regards working capacity, the labour force had been distributed at random over the years and this was unfortunate since it emerged that heavy physical work was being done by old workers, workers handicapped to a greater or lesser degree, delicate workers, etc., while on the other hand strong, young workers were taking it easy in jobs with minimal physical, environmental and other stresses, with all the intermediate situations involved in such a distribution.

Our first task was to prepare a complete table of the handicaps to be taken into account; we reached the following overall conclusion: of 3.400 workers, 900, or more than one quarter, had an appreciable handicap. Technicians, salaried staff and foremen were excluded.

We also studied all the jobs; our team, doctors and psychologists, worked in constant liaison with the heads of departments, foremen, workers themselves and, an important point, shop stewards, and we found 131 work places that in theory would allow 577 disabled workers to be employed, including the seriously handicapped: cardiac cases, amputees, the partially sighted, etc.

Then we had to match up these data: we obtained a decision from the management that assignments to these jobs would be subject to the opinion of a committee consisting of the personnel manager, works doctors, and the works psychologist. Thus we established "reserved" jobs within the company.

Practical application was not easy as the handicaps found amongst the workers did not necessarily correspond to the handicaps acceptable for each recognised job. Imponderables such as adaptation difficulties, resistance from foremen and workers, etc. did not always allow us to make the job transfers that were theoretically possible.

However, it has been found that this system, which is still in use after 13 years and is, of course, only one of the many possible solutions, enables us to resettle very satisfactorily cases that were apparently hopeless.

4. Continued medico-social supervision of the disabled. As the works doctor is in permanent contact with the company and is familiar with the jobs there, he is able, at the time of the decision to resume work, to help make the choice between the possible solutions, in liaison with the teams responsible for the care of the disabled person, in the widest sense; these solutions include: return to the former job, assignment to another job, reserved or not, within the same firm or in a different firm, or a temporary or permanent sheltered workshop.

He will, and this is very important, have to follow up the disabled person, observe the stages of his rehabilitation, and if necessary seek other solutions if the first or subsequent ones prove unsatisfactory. Here again, we proceeded as follows: a male nurse with humane qualities recognised by everyone is responsible for visiting the disabled person periodically at work and questioning him, the foreman and his workmates, to evaluate the quality, any difficulties or the failure of resettlement. Any difficulty pointed out by this nurse initiates a more or less complex process of revision of the case and always a further medical examination of the person concerned. Thus he does not have the feeling that he has been abandoned to his fate.

What conclusions should be drawn?

1. The resettlement of disabled workers is a difficult and complex task. It requires a clearly defined employment policy for the disabled, suitable legislation, the involvement of specialised institutions and multidisciplinary techniques, the main characteristics of which are now known but which unfortunately are more or less absent almost everwhere.
2. However, resettlement not only requires the establishment of theoretical models and the provision of adequate funds. Man is too complex, the factors involved too numerous for

schemes like this to suffice, however perfected they may be.

3. Each case is therefore an individual case. To draw a parallel with the clothing industry, that I have already used: tailor-made and not ready-made is what is needed in this field.

   For this we need not only great competence, but also great understanding, human warmth and the co-operation of all: governments, employers, wage-earners and experts in these matters.

4. The works doctor, throughout the complex process leading to the resettlement and employment of the disabled person, can make an important contribution that is sometimes underestimated. Although we are aware of the difficulties of his participation in this process of giving the disabled person a fair deal, we consider that he must be given - and if necessary must take for himself - the place to which his training, his experience and his position in the company would normally entitle him. It is not only a question of structure, but of efficiency and mutual understanding, for the benefit of the disabled person.

DISCUSSION

E. WULF

Mr. Chairman, Ladies and Gentlemen,

What the previous speakers have said (yesterday in particular) shows clearly how important it is that bodies concerned with rehabilitation should maintain liaison with each other. Now is the time to abandon theory and get on with the practice. The necessary conditions for standardisation in general already exist.

This relates not only to the respective areas of the individual members of the European Economic Community but, in view of the increasing mobility of labour, to the entire area of the European Economic Community. Time is running out.

An *essential* requirement for the rehabilitation of the disabled in the whole area is that *they* shall achieve their full competitiveness when they enter upon their *new* working life. It is self-evident that the wage should be *fully* equivalent, although doubts have been expressed about this. The external conditions necessary for achieving this aim - whatever the standard of education in a given case - such as the arranging of a job, the provision of a car, suitable living accomodation, should be greater. In West Germany statutory provision for these things has been made. It is incumbent upon us to implement them.

In my experience there is no aversion to the disabled in industry, particularly as they have generally received a double training. In the region with which I am familiar, the 1966 recession in West Germany did not result in preference for dismissal of the disabled. They even retained their jobs in preference to comparable able-bodied persons.

Further, we have to remain faithful to the concept that the aim of complete rehabilitation must be true re-education - occupational training. In my opinion we have at all costs to prevent the disabled person from as it were disappearing inside his works, his working environment, being rehabilitated "ad hoc", e.g. as janitor, telephonist or storekeeper. If this happens he will have been accomodated, but without being truly socially insured or made competitive. In the light of the figures presented I have the suspicion that this is frequently what happens. The authorities could not then do anything, although the necessary statutory provisions were there, because they heard nothing at all about these cases. Here the important problem of recording of cases comes into play, and the only solution is that the doctors, the practical, established medical men, the works doctors, make the decisive first move. The critical first contact is theirs. The decisive factor is the recognition of the case of disablement and the reporting of this. The disabled person will, whatever the reason, only very rarely be in a position to do this himself. I therefore appeal to the medical profession to act as the mainspring, so that the administration can - as I hope - intervene promptly (in this connection the information and advisory services available in West Germany call for mention).

In conclusion I venture to propose that when symposia are held in future the theoretical and practical knowledge that are represented there should be made the basis for the setting up of working parties for the purpose of devising recommendations as to how to combine to do effective work on rehabilitation in the setting of the European Community in exactly the same way as is done in the economic sphere.

L. de WULF

Mr. Chairman, Ladies and Gentlemen,

You will perhaps be wondering whether there is anything more to add to all that has already been said about the medical, functional and occupational rehabilitation of the disabled; about the legislation governing their employment and how they are to be put to work in open industry or in the sheltered workshop. In any case I am pleased to observe that at these various levels people have become aware of the problem of the disabled and their employment, and that all are willing to accept their responsibilities in this matter. I also appreciate that at the start of this Symposium it was urged that the discussions should be rigorously confined to the rehabilitation of the disabled, since there were certain fears lest it should become a platform for a programme of social demands on behalf of the disabled. However, I would suggest that a scientifically sound and humanly acceptable placement should take into account the social environment in which the disabled person lives. Many persons whose means of life have been assured by compensation lose this compensation if they become employed, whereas the aid that they had received is to be looked upon as financial compensation for the burdens and costs that their handicap entails, which coninue even when the disabled person finds employment. It is not enough to make equal wages a condition of employment, for the disabled person will then still be in a less favourable position than his able-bodied colleagues. Exemples have been quoted of the lawyer, programmer and, I would add, teacher with impaired vision. But these usually handicapped persons very often have to pay for extra help in order to exercise their profession, All this implies that in further studies of the employment of disabled persons account will have to be taken of the suggestions made in this connection by the different groups of disabled persons themselves. Thus, in our country we have the "Nationaal Komité voor het Belgisch Blindenwezen" (Belgian National Committee for the Blind), which is working out a programme of social action jointly with all the principal groups of disabled persons. At the international level we have thought that it would be useful to set up a "Coordinating Committee for the Associations for the Blind in the Countries of the European Economic Community". This Committee has been at work for three years. At its meeting on 18th and 19th May 1971 at Brussels, resolutions were passed on 10 items, some of which relate to our present subject.

I add these as an appendix. Moreover, I believe that it is of the highest importance that other groups of disabled should set up similar coordinating committees, so that the specific problems of these groups can be specified within the framework of the six countries and submitted all together to the Social Affairs Commission of the European Communities.

I am convinced that this commission will do whatever is possible to collaborate with us all in creating a Europe in which the disabled, too, can lead a good life.

RESOLUTIONS

1. Compulsory free schooling for all the blind in the six countries of the European Community.
2. Recognition of the right to occupational and social rehabilitation and integration for the adult blind.
3. Recognition of the right of all blind persons to work.
4. All blind persons, irrespective of age, income or fortune, to be given an index-tied grant as compensation fot the costs which blindness unavoidably entails.
5. The blind to enjoy the same social-security benefits, with the same guarantees, as the able-bodied insured.
6. An international travel pass for the blind should be issued, entitling the holder to priority of travel and preferential rates on all forms of public transport (land, sea, air).

   As an immediate measure, travel passes for the blind and existing preferential rates in each country of the Community and inside all other countries should be validated.
7. The public authorities should grant establishments and institutions engaged in the occupational and social rehabilitation of the blind subsidies on a sufficient scale to enable them to discharge their tasks to the full.
8. Modern equipment that the blind need in order to deploy

their energies should be perfected, manufactured and distributed.

9. Preferential aid for the blind in the countries associated with the Common Market should be coordinated at E.E.C. level.
10. The Coordinating Committee, or experts designated by it, should participate in the work of the European Economic Community on behalf of the blind.

J.-Y. BUISSON

As representative of an association of disabled persons, I should like to communicate to you some reflections inspired by this symposium.

Let me begin by telling you that the Association des Paralysés de France (Association of the Paralysed in France), to which I belong, has 45.000 members suffering from paralysis of the motor system, and is administered by a Council, three-quarters of whose members are disabled. It is in permanent contact with the disabled through the social services, its meetings, its friendly and leisure activities and its monthly journal, and it controls 8 % of the vacancies in France for those with paralysis of the motor system.

1. While I am extremely glad that an organisation such as the Community concerns itself with our problems, at the beginning of our work I feared that, as it frequently happens, the question of placing people in employment would be looked on from a purely economic point of view. Might not our society, while fully conscious of its obligations, be tempted to "lend a hand" (by means of rehabilitation) in order to recover a productive worker and no longer have to hear about the disabled person? Now, if a bargain is only a good one if both parties are satisfied, it is a question here in the first place of ensuring the welfare of the disabled person, the victims of an unjust fate. Economic considerations give

way to considerations of solidarity and justice.

2. Despite the conviction and good will of this meeting it has seemed to me that we are not sufficiently ready to listen to the disabled person and that among social workers we should beware of defining the welfare of the disabled for them.

Thus I believe that we should be flexible in the matter of work and beware of imposing rules of conduct on the disabled.

For one the best solution is employment in a normal environment, because it is compatible with his handicap.

For another, who is no more incapacitated for work by his handicap but is so for moral and psychological reasons, the sheltered workshop will be suitable. Thus there was the case of a dwarf who was fully active, but who, having experienced life in a factory, preferred the sheltered workshop, where he counted for something and was respected instead of being a butt for the able-bodied.

Work is a right, an opportunity offered to the disabled person, who already has to bear his physical defect. Except in rare cases a handicap does not imply a vocation for heroism. Let us therefore beware of imposing on others what we would be incapable of imposing on ourselves.

Thus in cases of severely and irretrievably disabled persons assistance may well be a normal and dignified solution.

We should also consider other ways of integration and participation than work, which admittedly has for millenia been the simplest solution. I would add that the vast majority of our members aspire to productive activity, wish to contribute to social life and consider it a duty.

Looking at the disabled from another point of view, I wish to stress how strongly our association objects to the mixing of the physically disabled with the mentally feeble in schools and holiday homes as well as in lodgings and sheltered workshops. The physically disabled, who wish for recognition from the able-bodied as adult persons capable of living the same kind of life, do not want to be seen in the same light as the mentally sub-normal, and fear that the public will see them like this. Thus we are very much opposed to mixed workshops, even though there are practical arguments in their favour and even though the physically disabled sometimes acquiesce in the arrangement, a bad solution being better than no solution at all.

Just as we lack studies of the repercussions that work has on the health of the disabled, so impartial research is needed into the desires and aspirations of the physically disabled.

3. I was profoundly interested in the "principle of finality" applied to our social legislation. It gives a legal foundation to a profound aspiration of the disabled in France, who feel indignation at the differences of treatment.

We will make it known and make use of it, as it perfectly corresponds to our idea of the "right to compensation". But the obstacles will be hard to overcome, and some of them will be put there by those groups which are at present the most favoured and which are determined to go on heading the field as far as social advantages are concerned.

I should like to tell you about a recent fortunate development in French thinking: social security for all, and the progressive abandonment of the concept of the obligation to provide subsistence in matters of social welfare.

4. I have been struck by the identity of views, preoccupations, aspirations, and action taken. Political Europe may still not have been created, but humane and socially conscious Europe exists.

The harmonisation of legislation seems to me a desirable objective, more on account of the opportunities it affords for action and remedy than as a means of regulating means, which must remain flexible. But urgent and necessary measures must not be delayed in our respective countries under the pretext of harmonisation. The financiers in particular are eager to seize on any excuse for delay.

5. Finally, may I as representative of the U.N.P,E.I., express the wish that the Community should concern itself with the grossly disabled, who are less numerous than the slightly or temporarily disabled but whose problems are so grave. I am thinking of severe cases of I.M.C., myopaths, sclerotics in casts. For them, other solutions than work must be found. They must be given adequate resources and conditions of life compatible with their handicap.

J. DAUHS

Mr. Chairman, Ladies and Gentlemen,

Before my accident I was an active sportsman and I often used to run furiously against a stop-watch. Today, in this symposium, I have to admit how much harder it is to speak against the clock. Therefore, speaking from the point of view of the disabled, I will limit myself to stating the following principles:

1. A general obligation to report every case of incapacity should be incorporated in the national legislation and throughout the area of the European Economic Community. The obligation to report should be incumbent on: doctors, parents and others responsible for the bringing up of disabled children. The aim is early recognition and early recording. All concerned should realise that recognition even one month early is of incalculable value for the disabled child in his journey through life.

2. Disabled persons take a finalistic view of handicaps. The reasons for the handicap carry no weight with the disabled or with the society in which they live. The only important thing is the handicap itself and the need for prompt and effective help.

3. A comprehensive survey of the number, nature and extent of the handicaps is the essential basis for purposeful planning. Therefore the Federal Union of the War Wounded and Civilian Injured, which I represent, has called on the West German Government to prepare an enquiry into the particular situation of the disabled in the school, the occupation, the family and society. It is recommended that such a design be put into effect throughout the area of the European Economic Community.

4. It is necessary that the nations, each acting within its own jurisdiction, should establish a chain of local centres, manned by qualified staff, for providing information and advice about rehabilitation, for giving parents or guardians, or the disabled themselves, reliable instruction about the facilities for rehabilitation.

5. More should be required of rehabilitation institutions than in the past, and this applies to both the institutions themselves and their staffs. Ideas about occupations and educational aims should be continuously adapted to economic and structural changes as they occur. Occupational rehabilitation should as a matter of principle call in the ancillary aid of medical and social welfare.

6. There should be an obligation on public and private employers to employ the disabled in posts suited to their knowledge and capabilities which give them the opportunity for the development of their occupational skills.

7. It should be the first principle of modern rehabilitation to strive to overcome the social isolation of the

disabled. It is therefore necessary to avoid excessive concentration of numbers. It is essential to ensure that the disabled are in constant communication with those around them in every phase of rehabilitation.

8. A vital condition for the total occupational and social integration and re-integration of the disabled is the removal or avoidance of all structural and technical obstacles. This symposium should not restrict itself to the ironical observation that the "stair" that I have just climbed was not made for the disabled, but should on its own initiative make an emphatic appeal to all town and traffic planners, architects, and public and private builders to overcome their indifference and thoughtlessness and fully to open up to the disabled this world in which it is his desire to live as a member of society, enjoying equal rights with others.

The disabled person does not wish, and must not be allowed, to remain any longer "standing outside the door".

A. MERCKLING

Defence of the tired worker and the idle disabled person

In a few decades we have passed from empiricism to the application of the exact sciences, from craft industry to mass production, and from the speed of the horse to Mach 2.

Modern man is becoming more and more ill-adapted to this artificial and hostile world, which provides "Ersatz" happiness and demands in return unheard-of sacrifices and the abandonment of the basic human values.

Alexis Carrel has spoken of the "disharmony of modern man", whom he describes as the man who, having felt himself growing the wings of an eagle, finds himself "a stray dog, wandering among the vehicles on the cluttered roads".

Our consumer society is caught up in an infernal cycle: production, sale, consumption, production, sale, consumption, at ever-increasing speed; creating new needs: production, sale, consumption,......

Haste and monotonous movement (remember Chaplin in "Modern Times") are succeeded by periods when time is dead: time lost in travel, time lost in riksome administrative routine, time lost here, there, all the time, everywhere.

In the cheap "HLM" council house sheltering the harassed worker he dreams of the little place in the country, but only gets there after endless hours spent in the irritating traffic queus which advance at a snail's pace ....he curses, wears himself out for nothing, and the road hogs do the rest. The so-called "normal" man is carried away by this fever and lives constantly on the verge of "breakdown" as witness the increase in mental ailments due to the stress of modern life.

In these conditions, in relatively mild cases, paradoxically enough, once the first emotional shock is over the traumatic state brings considerable relief. This is rest at last, life in utero, etc...., and what the psychologists write on this subject is their own responsibility.

Thus it need not surprise us if we encounter cases of aversion to resuming the insane life we lead.

Work no longer has any moral basis, ethics are no longer taught. Since craftsmanship is dead, and the only joy that work on the assembly belt offers is that of handling a little hard cash with which to satisfy needs which are imposed on us and eternally renewed.

It may very well be that there are cases of allergy to work, leading to a condition of dolce far niente and idleness.

Knowing the underlying causes of this, we should be able to reduce it.

It has been said that there are no idle children. I am convinced that this is also true of the normal, balanced man, who needs to be active, to assert himself, to create.

But work which is nauseating, is tiring and becomes impossible after a few hours, whereas work which gives some purpose to our lives lends us wings, and we become tireless. Committed people know something about this!

If we apply these reflections to the case of disabled workers, we conclude that after being made "secure" by rehabilitation they must have opened up for them horizons which give them scope for the unfolding of their new personality. It is only possible to do this in an atmosphere of confidence. Experts in dealing with the war-wounded have been recommended to welcome them as "comrades-in-arms". Do you not think that it is equally important for medical consultants, works doctors and social workers to rise to the same level of thinking and look on the worker whom they are to rehabilitate as an "alter ego", victorious in that "struggle for life" in which we are all involved together?

We should never forget that man does not live by bread alone, but also by the "word", the essential means of communication between man and man.

Let that word be sincere, and marked by understanding and good will.

In a word, we have to humanise our relations with our fellows, and humanise our institutions. There will then be fewer failures to adapt and fewer failures in social and occupational resettlement.

E. MARQUARDT

Mr. Chairman, Ladies and Gentlemen,

We are grateful to Herr GLOMBIG for his criticisms and for his constructive and forward-looking proposals. However, the Generaldirektion Soziale Angelegenheiten (General Board for Social Affairs)should not hide its light under a bushel or be too modest. In December 1970, Herr JOACHHEIM and I reported to the Plenary Assembly of employers and workers here in Luxembourg on the results of the programmes of research into traumatology and rehabilitation, which were financed by the European Communities. Appreciable results were achieved in every country, and there are of the greatest significance, mainly for the disabled, but also for the economy and social legislation. These results should be made accessible to you all. For instance, people who have had arms and legs amputated can be fitted with artificial limbs, and trained in their use, much sooner after the operation than under the earlier procedure for the approval of aids via the Federal Aid Law (BSHG). The constant interchange of ideas with the experts in the countries of our Community has been, and continues to be, of especial value to us; as indeed, have been our interchanges with the disabled themselves. We have here a basis on which, in support of the ideas expressed in the paper by GLOMBIG, we can press on more resolutely with practice-oriented rehabilitation research, which should, however, be conducted so as to have more effect in politics and on the public.

A. MARINELLO

The problem of the rehabilitation of the disabled has been brought ou into the open by the realisation of two facts:

1) The increasing number of citizens affected by handicaps, which are suffered by a very high percentage of citizens;

2) The need for some countries which are short of labour to obtain it by taking advantage of and making use of the disabled without regard to the origins of their particular handicap.

I believe that, just as a society protects itself against every kind of natural disaster, so it must protect itself against the serious phenomenon of accidents, misfortunes, and occupational diseases, if it really means to safeguard the health and the integrity of its citizens and allow them to play an active part in every aspect of labour, production and leisure.

We must not formulate the problem in purely economic terms, as Herr GLOMBIG has done, but must also see it as a human and social problem, and the solution of it must not be left to the State alone but must be passed over to the disabled and their institutions for independent action. The State has an obligation to provide suitable conditions, in particular finance, to enable the disabled, from the very start of the procedure for their care and advancement, to feel truly that they are striving for social reinstatement.

Thus, rehabilitation must be the first step that the disabled person takes of his own volition on the road of his personal progress. The society of each nation, and the European Economic Community, have the manifest obligation to take every step and adopt every measure, greater in number but identical in law and in fact, that they would for the normal healthy citizen, because the disabled reject the traditional forms of charitable paternalistic aid.

Thus the State will formulate its programmes, but their implementation will concern not the governments or the Commission of the European Economic Community, but the disabled alone.

I do not underestimate the importance of resettling the disabled person in a job for economic reasons, since this is implicit in every human action, but I maintain that the principal aim is the resettlement of the disabled person from the psychological and social point of view so that he can take his place in society as an equal member from every point of view.

R. KLEINE

I am very grateful to Herr WEBER for stressing in his remarks the willingness of the disabled to work.

I too wish to affirm emphatically that the great majority of disabled persons possess the will to earn their daily bread for themselves and not to be a burden on the community. There are asocial and work-shy persons and grumblers in every class of the population.

I am certain that the majority of the disabled see the securing of a place in society as the fulfilment of their lives; of course, the necessary condition for this is the appropriate degree of occupational achievement.

As representative of an organisation for the disabled I heartily endorse the view that the right to work has precedence over the right to compensation.

It is to be regretted that Prof. Dr. SYMANSKI, from West Germany, said yesterday here that many of the disabled are not so much interested in work as in compensation. This created the impression that most disabled persons in West Germany are chasing after compensation. I wish firmly to repudiate these prejudiced remarks.

I wish to thank all those who here in these past days have associated themselves with progressive rehabilitation with the aim of giving the disabled a life worthy of a human being and affording him the opportunity of playing a part in the social life of his country. I would ask you to untensify your efforts, so that throughout Europe the disabled can be released from their isolation.

I wish to issue an urgent warning against the setting up of a rehabilitation university for the disabled at Heidelberg. Anyone who is in favour of integration must not create a student ghetto. Help to ensure that the disabled shall be enabled to study at all universities through the removal of structural and technical obstacles at existing universities and the avoidance of them in universities which are being built or planned. Equal opportunity for all the disabled is the need of our time.

A. MOTTA

The decision to confine ourselves at this symposium to disabled persons of working age, carrying out manual or intellectual activities, afflicted with physical or mental handicaps, causes us to concentrate on the group which is by far the most numerous, those who have been incapacitated through occupational accidents or diseases or - more generally - by ailments or disabilities in some way connected with work and hence with lack of preventive action.

Persons disabled at work are not merely evidence of inadequate preventive measures by the employer but of the fact that such shortcomings are inevitable as long as production methods, patterns of work and the distribution of production are, as today, in conflict with sound principles of ergonomics.

This is inevitable as long as human labour is governed by the law of profit, the physical health of the workers and their integrity being secondary considerations.

It is therefore logical that human labour should continue to produce invalids, "technopaths", persons disabled by work, for as long as it is not the primary objective of the organisation of labour to promote the security and the psychological and physical integrity of the workers.

It seems relevant to make these comments, since to-day we find two types of approach to the problem of the disabled, whose contrasting nature is apparent rather than real:

- the first is based on the total exclusion of the disabled from all productive activity and their restriction as invalids to the class of "pensioned" persons;
- the second is based on the inclusion of the disabled in working life, but under marginal conditions and as unskilled persons, the inevitable result being a substantial degree of withdrawal and frustration.

It should be pointed out that this also happens through the use often made of selection by aptitude and of rehabilitation as methods not aiming at fully reintegrating the disabled into productive activity by adapting the work to the man and specifically to what is left of his capacities (although maximised by retraining) but again applying as the sole criterion, based on the assessment of his aptitude, the yardstick of productivity.

Thus, whatever technique of rehabilitation it is proposed to adopt, it is doomed to failure if - rejecting the notion that incapacity always is, or ends by becoming, a "psychological phenomenon even where the aspect of the functional mechanism appears to prevail - it is based on the criterion of "readaptation" to work in the laboratory in surroundings which are distant or detached from the working environment.

Lastly, the tendency to reintegrate the disabled person in active working life - whatever his residual psychological and physical capacity and his potential for learning - by employing him on marginal work often without significance or acceptable motivation, or utterly rejected by everyone and hence extremely frustrating, seems little better.

In our view, the only way usefully to reintegrate the disabled person into productive work is to make use of him with the object of requalifying him and seeking solutions that are commensurate with his residual capacities, not with the object of profit for whoever is employing him, the only consideration being the right of the disabled person to work and the duty of society not to disdain his remaining capacities, as has been asserted by so many of the earlier speakers here.

If these concepts are applied to rehabilitation, it will help the active reintegration of the disabled at the practical level if:

1) they are provided with an interim income with a view to their requalification, and therefore continued until they are reintegrated on an equal footing, with no question of exclusion, into the productive process, in a sphere which is compatible with the new abilities they have acquired; in certain cases this should be done at the expense of the firm which was responsible for their incapacity;
2) the retrained disabled person is placed in sheltered employment, and if possible his job is kept open for him in the firm where he was employed at the time of his accident, the occurrence of his occupational disease, of his injury;
3) his salary is made up so at least to maintain, if necessary, the level he had reached at work before the state of disablement came about;

4) in the case where the disabled person is a migrant worker, political and technical solutions are found whereby effective equality is granted as regards the right to rehabilitation, as provided for in Rule 1612/68 of the European Economic Community concerning the free movement of labour.

But a solution of the entire problem is possible to the extent that there is a genuine political will to give effect to the prior objective (full employment) of the social policies of the Community, according to which the workers always have the biggest voice, and are the subjects and not the objects of those policies.

J. PARIS

The various reports presented have emphasised the efforts made in the countries of the Community to enable disabled persons to find a place in the working world and become properly integrated in it.

In this process, which starts from functional rehabilitation and culminates in resettlement in a job, industrial medicine is ready to play its part. It will take concrete action at both ends of this process, at the beginning by indicating the jobs which might be suitable for the various handicaps and at the end by supervising the adaptation of the persons concerned to the trade.

For this it is sufficient to give it the means, that is, to entrust it officially with this task in the firm, and also to allow it the time necessary to perform the task.

In reply to the address by Mr. A. COPPE and the proposal "that'pilot projects' should be considered with a view to concerting the efforts made to discover appropriate methodologies", we think that implementation of this - in industrial medicine - could be attempted in different industries and different administrations. This would make it possible to study the potentialities of industrial medicine in its present form in relation to the whole of the general problem of the disabled.

N. RICCIARDI-TENORE

In view of the importance of the subjects dealt with, which concern not only the doctor, the sociologist, the lawyer and the psychologist but also and above all over 12 million disabled persons (that is the approximate number of disabled persons at present in the countries of the Community), I have followed with lively interest the papers given by the distinguished speakers who have succeeded one another on this rstrum.

Three points in all these papers have particularly struck me, and I should like to make my comments and observations about these:

a) Prof. GERUNDINI illustrated the importance and significance of rehabilitation medicine and also the extent of its involvement in the preparation of the disabled person for work, the early stage at which it must take action, the concrete nature of its processes right up to the actual recovery, by the disabled person, of the capacity for active and productive life.

b) Other speakers have stated that very often disabled persons are reluctant to make the effort to readapt themselves or to resettle themselves in the working world, perhaps cherishing hopes of possible welfare grants and subsidies which might be granted to them by the State.

c) Other speakers have mentioned the company medical service which, in addition to ensuring, within the firm itself, the existence at all times of all

> the hygiene and safety regulations, designed to safeguard the health of workers, or requiring employers to bring such regulations up to standard where they are inadequate or even non-existent, must also aim at placing the disabled person in the job best suited to his aptitude, taking into account the disabilities from which he suffers.

On this point I ask myself and I ask you: How is it that there are still so many disabled persons? How can we explain that the number of these disabled persons is constantly increasing? Are we sure ourselves that we, each within our own field of responsibility, have taken all the steps and introduced all the rules which were and are at our disposal?

In my humble opinion it is necessary to give more force and effectiveness to preventive medicine (prevention is better than cure has always been the motto), since it alone can suspect, recognise, investigate and, above all, prevent the direct or indirect unhealthy influences exerted by the work factor, wether the work be manual or intellectual - since work, although regarded as a physiological need of the human organism, can be transformed, in certain conditions, into a cause of damage to that organism.

The preventive action must be exercised not only by making employers as alive as possible to the need for the constant and full observance of all rules concerning hygiene and safety but also by making workers more accident-prevention-minded and, above all, by as far as possible keeping the various regulations up to date with the diverse and progressive development of industrial technologies.

With regard to works medical services, it would be desirable, indeed necessary in my opinion, that works doctors, too, who often have to grapple with difficulties of various kinds, should have their own legislation, a suitable legal and economic discipline, and true autonomy, and should no longer be regarded merely as subordinatesof the employer, in relation to whom they are, for obvious reasons, handicapped (to keep to our subject), especially on the psychological plane.

Only when we have complied with these rules, carried out these duties, performed these tasks, shall we be able to say with an easy mind that we have obeyed the repeated calls of our conscience, that we have brought out what is fairest and highest in the human personality, that we have rendered a truly memorable service to the working classes.

M. LENOBLE

At the economic level it is a laudable and fair thing to consider the handicap and not the person.

Too often we ignore the human aspect. We all feel, or have felt, the anguish of social non-integration. At some time in our lives - family, matrimonial or professional - we have encountered a certain look, attitude or silence which says a great deal about the non-acceptance of our situation by the other person.

It is the characteristic feature of man to "determine himself" in relation to society, and this entails reciprocity in acceptance. Hence there is acceptance of responsibility for everything by everyone.

Able or disabled has no meaning in a really human economy.

Living together is the result of mutual consent, that is, of a personal investment.

It is harder to receive than to give. Did not La Fontaine say that we often need someone smaller than ourselves?

M. MARRONI

Mr. Chairman, Ladies and Gentlemen,

I only wish to speak on one point in Drs. BASTENIER and GODARD's interesting paper on the relationship of the works doctor with the workers and the inadequate degree of cooperation which often exists between them.

So long as the works doctor is looked upon by workers as the boss's doctor, the hope for any kind of cooperation is destined to remain a pious wish!

The works doctor must be freed from his economic and disciplinary dependence on the company if there is to be any hope of such cooperation and at the same time of giving back to the doctor all his professional prestige and liberty.

But the problem can also perhaps be viewed from another point of view:

- how to make the workers themselves, instead of the object, the main architects of prevention by participating for this purpose in the organisation of work and in technological planning;
- similar standards of self-protection and self-supervision should be applied to the problems of readaptation of the disabled to work and their reintroduction into the production cycle.

Thus it seems to us that also in connection with rehabilitation and resettlement of the disabled in production we should appeal - not only to the technical experts, of course - but to the solidarity between workers and to the principles of self-protection with regard to health and of workers' participation in the organisation of work.

Thus resettlement - with the centre of interest shifted from the law of maximum profit to the ensuring of workers' safety - must take place in accordance with the ergonomic criteria of adaptation of the job to the man and - in the case of the disabled person - to his remaining abilities, raised, however, to their maximum potential.

This seems to us possible only within the framework of workers' participation, no longer on a subordinate level, in the distribution of working tasks within the homogeneous group of workers.

CLOSING SESSION - ROUND TABLE

Chairman: Mr. VINCK

Director General for Social Affairs
Commission of the European Communities

REPORTS

N. ACTON

I would like to express again the very sincere gratitude of Rehabilitation International for the opportunity of participating in this symposium. We had originally planned to organize ourselves a European Seminar on Vocational problems at this time, but we were very pleased to instead cooperate with the Commission of European Communities. The close parallels of our interests is indicated by the fact that five of the speakers on your program have been experts who are members of our Vocational Commission, Council or other bodies. In addition, members of our Vocational Commission have come from all over the world to Luxembourg for the meetings: from the Vinegards of Australia, from the sunny shores of Roumania, from the skyscrapers of Africa, and from the jungles of New York. We even brought a member from Great Britain! Consequently, in the few remarks I will make, I can give you some thoughts that have been discussed among our group which combines leaders in Vocational Rehabilitation of the countries in the European Community with those who engage in the same work in other parts of the world.

There is no doubt about the fact that we have been presented an exceptionally competent survey of some of the main problems and methods of vocational rehabilitation. At this session, we will hear summaries of the proceedings by

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three outstanding experts, and it would be superfluous for me to intrude into their tasks. I would, however, like to comment on some points which have been touched on in ten papers, and are especially relevant to future planning.

The first is to remind ourselves that the dangers of talking, thinking and acting about "THE DISABLED" as a group are much more serious than merely semantic. Not only do we obscure the fact that the function of rehabilitation is to assist individuals, but we tend to lose sight of the special problems of those individuals and especially of those who must cope with really serious and permanent disabilities. Statistics about successful rehabilitation of "The Disabled" invariably give a false impression about the degree of our success in connections with the relatively small proportion whose disabilities are at this extreme end of the scale of serious men.

A second, and closely related point emerges from an examination of the factors which, in our societies and communities, are responsible for turning a disability into an effective handicap. We cannot of course overlook the disability itself - the amputation, the paralysis, the loss of function, the damage, etc. The fact is, however, that with some exceptions, our science and skill have enabled us to repair or compensate for much of the direct problem. Our incompetence and failure are mainly associated with the environments in which the physical or mental limitation becomes a handicap: the physical environment and the social environment.

We have talked much and accomplished important things in the elimination of architectural barriers and in the improvement of public transport facilities.

Unfortunately, we have scarcely scratched the surface. There is no city in the world in which a person with seriously limited mobility can go to work and to the other activities of normal life without all kinds of special help. If you have any doubt, I suggest that you borrow or rent a wheelchair and try to live one day of your normal life in it. The vocational objectives of seriously disabled persons are more often frustrated by their inability to surmount unnecessary obstacles to mobility in getting out of their homes, to their places of work, through the functions of their job and back home again than by any other cause.

We have also erected social obstacles which effectively block the way to a reasonably normal vocational experience for those categories of seriously disabled persons which have been stigmatized. Progress in understanding the socio-psychological realities of prejudices against disabled persons and in developing reliable measures to eliminate it has been more by accident than by plan.

The rate of progress is such that we may hope to enter the Stone Age by the end of this century.

Several of your speakers have touched on these problems of the physical and social environment, and I bring you nothing new except the opinion that they represent the main problems about which we are doing much too little.

Thirdly, I would like to say a word about the basic validity of the work objective as we define it in the post-industrial revolution era and in the industrialized countries. It is very easy to produce cross-cultural data to demonstrate that our correlation of gainful employment with a satisfying life experience is not necessarily a valid proposition for all of mankind - and our work in the developing countries must take this account. In the countries of the Community, and in many others, the goal of an economically rational vocation is an essential component of a satisfying life experience for most persons, disabled or not - but, there are some important reasons to qualify that generalization.

The first has to do with the declining proportion of the individual's time and attention required for the satisfactory performance of work. As the 5-day work week becomes more and more common, the average individual spends only 35 percent of his or her non-sleeping time at work. We are seeing the beginnings of the 4-day work week which will make it possible to perform a job with the application of less than 30 percent of the time one is awake. In any case, there are today substantial blocks of the individuals time spent away from the primary vocation, and this is likely to be even more true in the future. As for the population in general, so for the disabled, the importance of leisure time increases accordingly. The qualification that this fact imposes on the concept of the vocational objective as the care of rehabilitation is obvious.

I believe it is also useful and necessary to realize that there is both variety and a degree of illogie in our designations of socially acceptable vocational activity. We usually attach the requirement that there be financial remuneration; but not always, as in the case of the housewife. In the cases of artists and other people who do creative work on their own, the evaluation is based more on the success achieved than on the time devoted to it. There are many interesting ramifications to the sociology of work. For the rehabilitation community, they suggest that we can and should open our minds to a greater variety of possible solutions to the problem of helping the seriously disabled person find a satisfying life experience. In some instances, the solution may include the performance of a form of purposeful activity which is not economically productive in the conventional sense but, because it solves the problem for the individual concerned, it should be supported. Some adjustments in our patterns of moving money around the society will be required if this kind of thing is to be feasible economically, but those are relatively small details if we can thereby improve the possibility for our seriously disabled citizens to have a life experience that is personally satisfying and socially acceptable.

Finally, in recording our appreciation for the fact that the Commission of European Communities has approached this symposium and its entire rehabilitation activity in a spirit of cooperation with others working in the field I would like to appeal to all concerned for ever closer international collaboration. It is obvious that we improve our efficiency and greatly multiply the effects of our resources when we avoid duplication of effort.

If there is one aspect of our general area of concern that today requires increased attention and therefore merits special consideration by this Commission, I would say it is the complex of problems affecting the life possibilities of those who are seriously and permanently disabled. In exceptional cases, due more often than not to the genius of the individual concerned, successful rehabilitation of the seriously disabled is achieved; but, in general, we end up with less than satisfactory compromises with both the individual's personal problems and the environmental obstacles we create. We need new and creative thinking, and will certainly welcome what you can do in that regard.

Prof. HOUSSA : synopsis on "preparation for placement"

The first part of the European colloquium on the occupational rehabilitation and employment of the disabled was devoted to a study of the medical role both during functional rehabilitation and during training to exert effort up to the stage of vocational training. The organising committee had limited the papers to general considerations, not wishing to go into specific cases. It was important first of all to define the concepts of invalidism and of disablement.

According to Dr. Noesen, a "disabled person" was considered in the past to be one who had lost his health or a function during the war; this deficiency was compensated by the grant of a pension; soon the term "disablement" confused the disabling condition with the pension. Subsequently, the victim of an industrial or traffic accident also came to be considered as a "disabled person".

Currently in the context of rehabilitation the term "handicapped person" was preferred, i.e. "one who required the benefit of certain advantages, aids and other measures to have the same chances of succeeding in his scholastic, working, social and family life; the advantages were not granted by way of compensation or reparation for anatomical lesions, but as a preparation for specific and appropriate tasks".

The assessment of the disablement was not necessarily related to the degree of invalidism, but was intended to determine the residual individual work potential in comparison to the situation prior to the pathological lesion.

In fact, "disablement" was a static concept and "handicap" a dynamic one, since for rehabilitation the aim was to secure a wage that was normal or even higher than that received previously.

According to Dr. Jochheim, the concept of the disabled person originated essentially by reason of the award of a pension, which society granted as compensation for a loss of function or anatomical loss involving depreciation on the labour market according to legal provisions.

If the disablement comprised three clearly defined factors, a deficiency syndrome, an effect on daily activities and a reduction in working capabilities, it was possible to obtain a favourable degree of reintegration into society by a rehabilitation programme. In fact, he rightly felt that the concept of disablement was directly related to the concept of work.

In conclusion, I consider that apart from the value of these reports the choice of the term "handicap" is the best from the human aspect since it replaces a series of terms used previously which were often rather disparaging.

It was Dr. Gerundini who discussed the role of rehabilitative medicine. He described in great detail the techniques and in particular the specific atmosphere in which the process should take place. He emphasised the need to apply it very early and to continue it until independence was achieved, or preferably up to the resumption of work.

All aspects of the patient must be carefully investigated from both the physical and psychological standpoints. This called for experts in various disciplines to form a homogeneous team that would depend on the disablement to be overcome. The predominant feature of rehabilitation was the spirit in which it must be conducted. Without a team spirit, successful rehabilitation was almost inconceivable. This was the fundamental, essential element that would enable the disabled person to regain his confidence in himself and in his human, social and occupational value. In other words, the disabled person was the most important member of the team, and as such had to be associated with his treatment and informed of his condition, the possibilities of recovery and return to social life.

It was desirable to use special ergotherapy that enabled a physical lesion to be corrected while reproducing on specially adapted machines the working movements peculiar to the trade of the disabled worker. This special ergotherapy facilitated and speeded a return to work.

This detailed report shows the importance of doctors and medical auxiliaries in rehabilitation. For this reason Dr. Houssa urged that the curriculum for medical and paramedical studies should include special instruction on rehabilitation; too little time was devoted to it and there were too few departments for this subject in our European universities.

We hope that this colloquium will come to the attention of the authorities so that rehabilitation may finally occupy the position that the disabled expect, thanks to the information provided.

Some comments were made after these papers.

A speaker from the Federal Republic of Germany rightly thought that any interruption in working life caused difficulties in starting again later and that co-operation between industry and the rehabilitation centres was desirable. This is very true, and advantageous arrangements have already been introduced in many countries.

Mr. Lenoble correctly stressed that speakers had not mentioned the acceptance of the disabled person by society. This comment was quite justified and it is obvious that if the handicapped person has to accept his disability, society has to accept the disabled person.

As a sociologist, he wished the environment in which the handicapped person had to live to be studied in advance. Personally, I think it preferable to try to get the disabled person to live in a normal environment.

Several speakers - Dr. Venema, Mr. Cooper - stressed the need to teach rehabilitation to doctors and their auxiliaries. However, Dr. Venema would like to see functional rehabilitation centres set up within general hospitals.

In the Netherlands there were four university departments and rehabilitation was a recognised subject for specialisation.

Mr. Cooper thought that sometimes the medical practitioner's ignorance of rehabilitation hampered the resettlement of the patient.

Prof. Cesa-Bianchi stressed the importance of mental rehabilitation and the need to influence the family of the disabled person and even society. This is in fact the practice in some countries, and this points up the need to establish a European approach to rehabilitation.

Mr. Graviotto would like staff in the centres to be familiar with the working environments and supported the need to establish special instruction.

Messrs. Pierquin, Cahen and Storm were studying the methods and conditions of rehabilitation for work.

The patient could not always go straight back to work after functional rehabilitation and some would be forced to change their occupations.

For all groups an intermediate stage is necessary, that of training to exert effort for one group and vocational retraining for the other.

The disabled person who had to learn a new trade had to acquire new knowledge - both theoretical and practical - as described at length in the papers. Therefore it was necessary to train the patient for a new working life by combining gymnastic activities with workshop activities.

The new occupation will be chosen after an aptitude test or after continuous guidance based on observation of the behaviour of the patient, given periodic aptitude tests.

Mrs. Mutterer and Mr. Boll presented papers on vocational training.

Mrs. Mutterer rightly considered the problem to be a difficult one: the handicap existed, the sequelae might be severe and working life was not yet free from fatigue and barriers. Various factors played a part in the choice of training method, mainly age. Training might be given in a conventional technical college or in a firm, which often meant a more rapid return to economic activity.

Correspondence courses could be a help to some seriously handicapped people. Lastly, specialised vocational training centres were often set up at the instigation of the disabled.

Mr. Boll felt that 80% of the handicapped persons of working age could be integrated into the general economy regardless of the origin, severity or incidence of their handicap if only all the modern rehabilitation aids that were currently being developed and tested, and were hence feasible, were made available to them.

This optimistic statement was followed by a masterly paper which is in fact a description of existing facilities and projects that could be put into effect once the necessary equipment and qualified instructors were available.

It appears that the working future of the handicapped will be brighter if what Mr. Boll describes can be put into practice.

Several people spoke:

Dr. Demol considered the case of young hemiplegics and said that alongside the primary disorders there were also secondary ones often requiring the use of very complex techniques and making occupational rehabilitation impossible. He stressed the need for instruction in rehabilitation during normal medical education and at postgraduate level.

An Italian speaker wondered wether, since the handicapped person often had complexes, he should be taught various trades as an encouragement and spur to activity.

Dr. Monticelli started occupational rehabilitation immediately upon clinical recovery in a homogeneous group using normal machines and basing the choice of occupation on the needs of the regional labour market.

Miss Fouchez wanted more comprehensive information and an extensive exchange of personnel, equipment and methods, and a lowering of customs barriers for essential equipment, prostheses and ortheses.

A speaker from the Federal Republic of Germany made the valid point that architects should finally concern themselves with the problem of the handicapped in their projects.

Lastly, Dr. Jochheim hoped that aid from the European Communities would continue both for research programmes and for the pursuance of international co-operation in the field of rehabilitation.

Personally, at the end of this summary on the preparation of the handicapped for work, I want to stress the important role the EEC can play in the future in informing those engaged in rehabilitation and then in educating the public, and finally also the national authorities.

As a result of this colloquium we shall return home with greater optimism about the industrial rehabilitation of the seriously disabled and their social and occupational resettlement.

May we express our sincere thanks to the Commission of the European Communities for giving us the opportunity of mutual enlightenment and information during these three days, on this humane topic, to the advantage of those struck down by fate.

M. HOFRICHTER: synopsis on "placement"

Job Procurement

Both the papers read here and our discussions have shown that the rehabilitation movement has been making progress on a broad front in recent years. Occupational rehabilitation of the disabled has come to be recognised as a primary social responsibility. The course of the symposium has revealed, however, that the route towards common objectives still presents considerable problems and differences of approach, among which I would single out the following as the most important:

1. Legal regulations and arrangements in the member countries

Messrs. MARON and VELDKAMP, in their papers, traced the impressive development which has taken place in our century from simple social aid to the individual's right to resettlement and work. Though the member countries have shown parallel trends, there are still differences both in the definition of claims and in the range of benefits. The Community countries should accordingly take steps to ensure that the right to occupational rehabilitation or to work is guaranteed to every disabled person, regardless of his position in law or of the cause or origin of his disablement. For this purpose, their policy on rehabilitation should be so designed that all disabled persons in the same circumstances are treated in the same way (e.g. regarding the scale of maintenance granted to a person being rehabilitated and his family, the payment of pocket-money, the payment of fares to and from home while staying at an industrial training centre, etc.).

The member countries of the Community, having harmonised their legislative and other arrangements, their next aim should be to make it possible for every one of their citizens to exercise his right to rehabilitation in any part of the Community, regardless of his own country of origin.

Mr. VELDKAMP was much concerned with the question of whether, in response to present-day pressures, the causality principle should be abandoned and superseded by the finality principle. This is not to deny the importance of referring disabled persons to a given institution within the social security system on causal grounds. But such a system should not carry its method of classification to such a length as to jeopardise the disabled person's general right to rehabilitation. The question arises how far, having regard to the accidents of historical growth, both principles can exist side by side. In any case, the individual's right to rehabilitation ought to be fully and effectively safeguarded by legislation and administration at all times.

2. Information and counselling

The importance of timely, realistic and comprehensive information has been underlined again and again. Investigations confirm that people's ideas of what rehabilitation can do are extremely sketchy. The social security systems of the member countries of the Community should therefore build up a close network of offices capable of providing general information or of undertaking responsible counselling to good purpose.

3. Essential role of the expert

In this connection it has been stressed that the days of the all-round counsellor who knows and can do everything are, for all intents and purposes, numbered. When it comes to finding jobs, it is essential in certain cases for rehabilitation counsellors to be supplemented by doctors, psychologists and technical advisors if the work of rehabilitation is to be permanently successful.

4. Quota system

This system stems from the misconception that firms employing disabled persons are inevitably handicapped, and so runs counter to rehabilitation policies aimed at enabling the disabled person to be fully productive in his job and to hold his own in competition with the non-disabled. The quota system can, however, make a positive contribution towards the solution of numerical problems in special situations (e.g. after a war, or in the case of structural shifts and territorial adjustments).

The European Communities should provide their member countries with an objective assessment of a quota system's pros and cons.

5. Procurement and selection of jobs

Ideas of practice, organisation and principle in this field are somewhat conflicting, and Messrs. MIROT and SALMON deserve our gratitude for having analysed them so fully. They were clearly right to insist that labour exchanges should have a special department concerned solely with finding suitable work and occupations for disabled persons. This also poses a number of technical requirements, but their importance should not be exaggerated. What matters is that the rehabilitation counsellor identifies himself with his patient, and that he paves the way for the disabled person's placement in work with enthusiasm and with knowledge of all the possibilities, backed by his patient's own determination to succeed. It would be mistaken, however, to treat jobs, and what they involve, in isolation. Success at work demands that a number of social and psychological factors inside and outside the firm are equally taken into account. This is not easy, and calls for experts endowed with the qualities of leadership. It would be welcome if the Community, in the light of the experience of its member countries, could work out guidelines for the procurement and selection of jobs which are based on pragmatic premises and assist every-day practice.

6. Return to the old job

That the work of rehabilitation is primarily directed towards making possible a return to the old job is perfectly natural. In many cases this is also all that is needed. Yet, however obvious, this should not stand in the way of some alternative solution which meets the needs of the individual in question and of disabled persons in general more effectively. Here again we are up against a problem of substance, which has to be tackled with a corresponding sense of responsibility.

7. Exchange of experiences

Several papers and comments have pointed to the need for organising an exchange of experiences on a broad scale. This proposal has much to commend it, and the Community is the obvious channel through which such a flow of information, which transcends national frontiers, should be centralised. Action might be taken under the following heads:

- Exchange of experts;
- Information on the design and implementation of programmes for creating work and job opportunities;
- Calling attention to techniques, new equipment and machines.

It also seems that not enough advantage is being taken of the opportunities provided by the large industrial trade fairs in the member countries for keeping tabs on advances capable of helping to open up new and additional employment prospects for the disabled.

8. Training of rehabilitation specialists

The success of rehabilitation policies and the effectiveness of rehabilitation programmes depend on an adequate supply of competent rehabilitation specialists. This calls for a great deal of work. Objectives for Community action here are:

- To establish career structures for rehabilitation specialists;
- To establish a European institution - seminar or academy - offering standard and advanced training courses for rehabilitation specialists.

9. Sheltered employment

The papers given by Mr. HEERING and Mr. LENNIG left no doubt that "employment and resettlement in a protected working environment" is highly advantageous as a second labour market and essential for the purpose of rehabilitation. Mr. LENNIG's suggestion of "workshops for disabled persons" to be used as a technical term is a sound one. Altogether, the headway made in this field has produced excellent results.

In order to facilitate further progress in the face of a tremendously heavy volume of demand, however, and also to avoid blind alleys, it would be useful to formulate guidelines on how such workshops should be equipped and organised. These guidelines should also provide an answer to the question, which Mr. LENNIG raised at the conclusion of his paper, as to how economic considerations are to be reconciled with social needs.

It should not be regarded as evidence of a critical or lukewarm attitude towards sheltered workshops to insist that, as far as disabled persons destined for or already working in them are concerned, the possibility of their entering the free market must always be carefully borne in mind.

The provision of financial incentives to firms employing disabled persons has been suggested as a half-way house. Though subsidies doubtless benefit the cause of occupational rehabilitation, their scale and duration ought nevertheless to be carefully scrutinised, so that technical measures by employers to improve the performance and productivity of disabled workers are not discouraged.

1o. Attitude of the disabled towards work

One suggestion made in this connection was that three types of attitude might be distinguished - good, middling and poor. This kind of classification does not, however, seem to me to serve a useful purpose. In the first place, work represents for the disabled, no less than for others, his source of livelihood, but it also helps him to come to terms with himself, to become less dependent on others and to live as man among men Again, his attitude to work is conditioned by the manner of his preparation for it, by his job prospects, and by his counsellor's ability to convince him not only of the advantages of a particular rehabilitation programme but also of the importance of work as a staff of life. Unfortunately, the effect of some bureaucratic procedures is apt to be inhibiting. We must therefore all ensure that the routine side of administration is completed as quickly as possible and that, where there is doubt about which particular department is responsible, the person applying for treatment is not kept waiting for weary hours on end. To obviate this, it will always be helpful if the institutions concerned agree appropriate procedures in advance.

Effects of economic change and technological progress

Technological progress and economic change are factors whose importance has been assessed in varying ways. Suggestions that their consequences are harmful seem unduly pessimistic. It is precisely through progress in technology, as well as in the scientific and medical field, that we are able to overcome the outstanding problems of rehabilitation more effectively.

Indeed, there is no other way in which social claims can be met, human suffering alleviated and economic exigencies also duly taken into account.

11. Publicity and research

I have already pointed out that public awareness of rehabilitation is low. Hence the need for greater publicity to influence the public in favour of rehabilitation, remove prejudices and improve the flow of information.

Vitally important research undertakings at present subsis on fortuitous initiative and sporadic enterprise. The Community could render an enormous service if it designed and implemented a strategy for research at an early date. Experts of the principal disciplines such as medicine, psychology, technology, vocational counselling, sociology, etc., should be called together from the member countries to work out a long-term programme which will assist the scientific side of rehabilitation in a decisive manner. Talking about science, let me stress once more what has already been said so often, that strongholds of science like the universities, research establishments and education should pursue the study of rehabilitation with the urgency which its importance as a preeminently social question demands.

Conclusion

Enough has been said here to show that past progress, however considerable, and present achievement in the field of occupational rehabilitation offers no cause for self-satisfaction. Just as we demand that the disabled daily master themselves afresh, so the European Community should mobilise its energy and resources jointly with ours to set new examples of rehabilitation for society to emulate in more ways than one.

Dr. VELDKAMP: synopsis on "points of view"

I. The difficulties of summarising the opinions of the various groups concerned with occupational rehabilitation and the resettlement of the disabled are such that the rapporteur summing up can only give a résumé of what the individual speakers said in their excellent papers. And I have the feeling that not everything that is relevant has been said. This is particularly true of the viewpoint of the disabled themselves. While listening to Mr. GLOMBIG's address, I had more the feeling of listening to a very good argument relating in particular to the German situation from the standpoint of a Member of the German Federal Parliament than to the argument of those representing the viewpoint of the disabled. Indeed, Mr. GLOMBIG himself pointed out that he was not expounding the position of the disabled in the traditional way, but that his remarks mainly applied to the policy of the European Communities and of the Commission. In various expositions by disabled persons in the past few days, we have also heard other views, and I had in fact expected these to be put more systematically at this morning's session. I am thinking in particular of the complaint expressed on the part of the disabled that they are always asked to adapt to the society in which they live and that it is very rare for the various social institutions to be required to adapt to the disabled in our society. And above all it will be necessary to seek a solution together with the disabled. Various sciences, such as sociology, social psychology and social medicine should concern themselves with this subject on a multidisciplinary basis.

Mr. GLOMBIG rightly began his presentation by once again drawing attention to serious difficulty facing social policy as a whole in the European Communities. The Treaty of Rome's treatment of social policy is rather parsimonious, although it has been repeatedly argued that much could be achieved by a broad interpretation of the Treaty and the good will of the member states in collaborating in such a broad interpretation. The Commission of the European Communities in particular, however, cannot be accused of having failed to display enough initiative in this connection, either in the past or in the present. It may perhaps be said that this did not fully apply to the EEC with regard to our present subject, but nevertheless the E.C.S.C. certainly devoted considerable attention to it. I agree with Mr. GLOMBIG that our colloquium could be an important catalyst for a European policy on the occupational rehabilitation and resettlement of the disabled, and that also the policy of the member states might, as a result of our meeting, be strengthened. However, in some respects, my agreement with him goes no further. Mr. GLOMBIG believes that the decision of the Council of Ministers of the European Communities of 13 March 1969 must lead to a concrete political action programme and must not get bogged down too much in theoretical discussions about definitions and the like. He pleads for a concrete political action programme which - on an agreed compromise basis - can secure the approval of all states and is co-ordinated with the policy of other bodies, such as the Council of Europe, the World Health Organisation and the International Labour Organisation. I do, of course, very much agree with these last two points. The Commission, under

Articles 117 and 118 of the EEC Treaty, can, of course, undertake anything, but if the Council of Ministers, particularly in matters such as these, which fall within the competence of national governments, does not agree, its activities have less chances of success than if agreement is forthcoming. And if the Commission were to undertake the same action as the Council of Europe, the WHO and the ILO, this merely means a waste of time and manpower.

I have much more difficulty with the concrete action programme which must have little to do with theoretical discussions about definitions and the like. I am, of course, enough of a politician to know that a policy must be as concrete as possible, but at the same time I am enough of a scientist to know that political programmes in areas such as the one which we are discussing are dangerous if they are not based on thorough and co-ordinated scientific research. For this reason I should like to make an important amendment to the views of Mr. GLOMBIG, distinguishing between short-term and long-term policy aims.

Naturally we can ascertain what concrete action can be taken in the short term on the basis of what we already know, and that is not so little. This is also necessary in order to make the large group of disabled persons amongst us believe in the reality of the European policy, but also, no less important, to persuade them that the rights which are universally proclaimed as sacred are actually being translated into reality by the politicians. This is bound to entail thoroughgoing, co-ordinated research, which must therefore be on a Community basis, to be undertaken in order to initiate a long-term policy for the disabled, which at the same time will constitute a social and economic horizon for the disabled in the Europe of tomorrow. I do not necessarily agree with Mr. GLOMBIG's statement that the Council of Europe, in the twenty years of its existence, has adopted thirty recommendations and resolutions which have had very little follow-up. I believe that the activities of the Council of Europe in the field of rehabilitation policy have in fact been of great importance, but if Mr. GLOMBIG means that we in the European Communities must willingly co-operate with the Council of Europe and the international organisations in order to achieve more far-reaching practical results, then I am absolutely in agreement with him.

II. Regarding the type of programme to be elaborated by the European Commission, I agree with Mr. BALME, Mr. WEBER and Mr. GODART that, however much attention we devote to rehabilitation, prevention must not be forgotten. In this connection I should like to express my personal view that there is a very great need for co-ordination of the prevention of accidents. In many countries, entirely separate bodies deal, for example, with the prevention of industrial accidents and road accidents. If I remember rightly, the number of accidents taking place outside industry and off the roads is many times the number occurring in these two sectors. However, many accidents occur in similar circumstances and manifest themselves in the same way, regarding both their configuration and their consequences. It seems to me that acceptance of the finality principle, which is generally acknowledged here, requires that the prevention of all accidents should as far as possible be integrated, both nationally and internationally. This cannot be overemphasised, because, however successful rehabilitation may be, this is a classical case of prevention being better than cure.

All speakers - Messrs. GLOMBIG, BALME, WEBER, BORSTLAP, BASTENIER and GODART - have raised important questions which must be investigated in the establishment and elaboration of the programme. Of these, I would refer to the following:

1) Full implementation of the principle of like treatment for all classes of disabled persons. This appears to me to be a logical consequence of acceptance of the finality principle.

2) Compulsory registration of all disabled persons. This requirement - which emerged from the discussion - also seems to me to be consistent with acceptance of the finality principle.

3) Optimum organisation of rehabilitation.

4) Provision in the national legislations of the member states for Community rehabilitation centres and the exchange of experts from different member states. This seems to me to be of very great importance. At a meeting like this colloquium, every one of us will constantly have the feeling that in some fields one country and in other fields another country is ahead. Through exchanges we can exploit each other's knowledge, and this can, of course, be particularly effective in a Community rehabilitation centre. It would be a most welcome development if the Commission were able to set up a Community rehabilitation centre of this kind with finance from the Social Fund.

5) Co-ordination of research and documentation. No one will be surprised that I support this wish, expressed in particular by Mr. GLOMBIG and Mr. BORSTLAP, after what I have just said about long-term policy.

6) Community criteria for a European disabled person's identity card.

7) Close contacts between the bodies responsible for social rehabilitation and the offices in touch with industry.

In this connection, I agree strongly with Mr. GLOMBIG's view that the Social Fund of the European Communities ought to be activated with regard to the institutional side of rehabilitation and co-ordination with other bodies.

Still in the context of the requirements of a programme to be established by the European Commission, I would mention the following points, amongst those expressed:

1) The necessity of accessibility of rehabilitation facilities for the disabled, so that the disabled person himself does not have to search for these facilities, which often seem to him maze-like and impenetrable.

2) The emphasis, from all aspects, on the necessity of implementation of the causality principle. Mr. GLOMBIG pointed out in this connection that the rehabilitation of children and of adults must not be separated. After my own argument about the necessity of abandoning the causality principle, it is not surprising that I am very much in favour of this view of rehabilitation. However, I would add - perhaps unnecessarily - that of course particular aspects must be distinguished for the different groups. The rehabilitation of children in my opinion entails different requirements from the rehabilitation, or, if you like, the resocialisation, of the old.

3) The necessity of constituting, on an institutional basis, a closed circuit of action. In this connection Mr. BASTENIER and Mr. GODART stressed the importance of an early start to and continuity of rehabilitation. In my own country I have heard rehabilitation doctors say that rehabilitation should begin on the stretcher.

4) The requirement that rehabilitation must not lead to isolation. Mr. BALME, Mr. WEBER and Mr. BORSTLAP rightly emphasise that apartheid must be avoided in all action. For this reason, as Mr. GLOMBIG said, integration in all groups is necessary, as well as the co-operation of all groups and, not least, of the disabled person himself.

5) Mr. BASTENIER and Mr. GODART plead in particular for the close collaboration of the workers and their representatives in rehabilitation policy in the framework of industrial medical services and all other bodies more specifically concerned with this aim and accepted by both sides of industry.

III. Various speakers have referred to the important economic and employment aspects of the subject of rehabilitation. Mr. GLOMBIG mentioned the growing number of young invalids. These increasing numbers represent a huge burden for member states, in connection both with the social security cost and the loss of output, especially, according to Mr. GLOMBIG, in Italy.

Mr. GLOMBIG rightly pointed out that rehabilitation is a form of social policy which does not only cost money. A considerable multiplication factor is also involved. Mr. BALME and Mr. WEBER, too, mentioned the economic value of rehabilitation, but rightly added that rehabilitation also benefits human dignity. Mr. BORSTLAP said the same in his paper: efforts to reintegrate disabled persons in the working process were justified by the value of the work, not only from the economic viewpoint but also as a means of achieving human self-realisation. The necessity of the co-operation of industry in rehabilitation is generally recognised. Mr.BALME and Mr. WEBER correctly said that employers must provide the jobs, and that funds were required for this. They note that the decisive factors for resettlement are the development of the labour market, the effectiveness of the occupational rehabilitation and the removal of prejudices against the disabled. This exposition from the employers' side is supported by the representative of workers, Mr. BORSTLAP, who gives preference to work for the disabled in normal industry rather than in a sheltered environment, adding that there should be a legal obligation for the employment of the disabled in industry, and the income of a disabled person at work should be made up to the same amount as is earned by his non-disabled colleagues from social security funds. The employers are not in favour of this compulsion. Mr. BASTENIER and Mr. GODART, who are rehabilitation doctors, also consider that industry should have a specific policy for the disabled.

Clearly, a great deal of research is necessary in this field. In my opinion, we need a better knowledge of the labour market and the possibilities it offers to the disabled, as well as research into the relationship between the social security system and employment policy. I should perhaps make one thing clear: that when I speak of employment, I mean all aspects of the labour market. Jobs for the disabled are primarily industrial - certainly as far as sheltered employment is concerned. However, it is necessary to extend our examination to the whole of the tertiary sector.

IV. The speakers also referred to legal provisions. I have already mentioned that the workers' representatives consider compulsory measures necessary to achieve the admission of the disabled to industry, but this view is not shared by the employers. On this point it is my view - although I consider legislative compulsion to be essential - that the primary requirement is a change in attitudes. This is another instance where the old adage that good customs are better than good laws applies. The rehabilitation doctors, too, would like the law to be more specific about employers' obligations in the placement of workers. They point out that if the Community accepts the right of the disabled to work, it must provide itself with the means to achieve practical implementation of the law.

This is undeniably another reflection of the realisation of the finality principle, that an end must be put to discrimination according to the origin of the disablement. However optimistic one may be about this, the truth of the matter is, of course, that the finality principle is far from being put into practice in the member states of the Community. According to many experts, a number of difficulties must still be overcome with the implementation of the finality principle in the different member states. I wonder whether it might not be desirable for the European Commission to compile a list of these difficulties and have them investigated by an independent research institute, such as the European Institute for Social Security, expressly qualified for this.

A particular aspect of legislation in this field relates to vocational training. Mr. BALME and Mr. WEBER have pointed out that where vocational training measures are concerned, the development of policy as regards the labour market must be taken into account, and that close contact must therefore be maintained with industry. They consider that where possible all vocational rehabilitation measures should be based on the subject's most recent occupation. Wherever possible, the subject should resume his former job in his former firm. For this reason the firm must also play a very important part in occupational rehabilitation. In this connection too, according to these speakers, legislation must provide an impetus. Nevertheless, rehabilitation centres for occupational training should be available. The necessity for decentralised institutions and a varied supply of training opportunities are both important. Mr. BALME and Mr. WEBER made the point that the centres should endeavour in this connection to approach closer to industry and to practical conditions. Optimum organisation of the training measures is necessary, as regards their duration. For the disabled as for the worker in general, occupational mobility must be allowed for by a wide basic training. The foundation can be the subject's existing occupational experience. The training programmes must take account of the dynamics of the economy. The disabled must not become second-class workers - a point rightly stressed by Mr. BORSTLAP. This ties up with Mr. BORSTLAP's remark that disabled persons whose residual productive capacity is so low that they cannot be placed in normal industry belong in social employment. As he correctly states, social employment is not intended for older unemployed workers or social misfits, and, as Mr. GLOMBIG points out, is in principle also no solution to the problem of permanent employment of the disabled.

What then is the role of social employment, one may ask? Social employment has developed considerably in a number of member states as an alternative source of job opportunities.

But in my opinion, the question arises of the function of this institution in our society in the immediate future. Is it right to concentrate so much on productive work? Is it really necessary to aim at firms in the strict economic sense of the word, with minimisation of losses as the primary object? Should the objective be concentration or decentralisation? Should the organisation of life not be a more central factor, with an eye to the mental well-being of society? All these are questions which demand answers. Research into these points is urgently necessary on a European scale; it must involve the experts who have shaped sheltered employment in the member states.

V. To end my summing-up, I should like to express my agreement with Mr. GLOMBIG's view that disabled persons in the countries of the European Community must have optimum rehabilitation facilities. I would emphatically add that this must also apply to the young, to housewives and to the old. For this purpose short- and long-term programmes must be established. The former may be concrete, based on existing experience. The latter require thoroughgoing co-ordinated research on a Community basis. This demands finance, which may be obtained from the Social Fund of the European Communities and from the relevant social insurance funds. A large number of problems must be solved in the most modern possible way; of these, I have mentioned the relationship between social insurance and the provision of employment for the disabled, an effective critical analysis of the difficulties and they ways by which these might be overcome concerning the implementation of the finality principle in the legislation of member states, and the correct form of social employment. In addition, important questions of vocational guidance and training for the disabled must be investigated. Lastly, research will be necessary into the needs of a large group of severely disabled persons, whose rehabilitation cannot lead to work of any kind, but for whom we must seek, with them, to secure as useful as possible a purpose in life.

If the European Commission succeeds in solving these problems, it will not only have made an important achievement in social policy for the disabled of Europe, but will also have shown that it is possible to apply a European approach in the field of social policy as well as in other fields. I fervently hope that the Commission - and also in particular Mr. VINCK, who has been the driving force behind its action - will succeed in this aim.

Mr. VINCK: closing address

My task is a relatively simple one. The most important technical work has already been done by our three rapporteurs.

It falls to me to draw the political conclusions of this Colloquium.

I should like to start by reminding you how the Colloquium originated. Within the ECSC we have already carried out important research into the rehabilitation of the victims of accidents and occupational diseases in the coal and steel industry.

In recent years there has been a disturbing increase in the number of disabled persons for various reasons that have been discussed at length during the Colloquium.

The Community institutions - Council and Commission - were rightly concerned about this and the Council of Ministers asked the Commission to put forward proposals on the co-operation that could be established between our six countries and between the Council and the Commission on this serious problem.

And now I should like to reveal a little secret to you and at the same time express my particular gratitude to Mr. Régniers, President of the International Society for the Rehabilitation of the Disabled. It was he who had the intention of organising a colloquium on this problem and with his willing consent the Commission took over the idea from him. We wish to thank him publicly here.

And I should also like to remind you of the title: "European Colloquium on the Occupational Rehabilitation and Employment of the Disabled".

This limited aspect has been selected and consequently the objectives are also limited, but this does not mean that the Commission is not aware of the many other aspects of the problem of the disabled. It was aware of the dangers of being overambitious.

I say without false modesty that this first colloquium organised by the Commission of the European Communities, this first effort, is a brilliant stroke.

We have had the honour and pleasure of assembling a group of rapporteurs and co-rapporteurs embracing a range of knowledge and experience unique in our Community.

We have also had the honour and the great pleasure of welcoming representatives of by far the most important international organisations concerned with this problem:

The International Labour Office
The World Health Organisation
The Council of Europe
The International Society for the Rehabilitation of the Disabled
The International Social Security Association.

I am also thinking of all the experts from the countries that we still refer to as "third countries" and of all the experts in this field not only in and of the Community but also from other Western and Eastern countries. This bodes well for the progress of activity in our field in an enlarged Community.

The aim of our Colloquium was clearly defined by Mr.COPPE when he said that we must as far as possible rehabilitate men and women rather than pension them off prematurely; we must open up the labour market to the disabled and *keep it* open.

He said that we had decided to make occupational rehabilitation and employment the central theme of this Colloquium because it was felt essential to find a link between the medical and vocational stages of rehabilitation. All too often, today, we could still only respond to the uncertainty of a disabled person by limited and short-term prospects. How could we hope under these conditions that he would have sufficient incentive to pass successfully through the various stages suggested to him? An adequate chance of success could only be ensured by taking charge of the complete process from the start so that the person concerned is assured of effective co-ordination between the *successive means to be used and had the certainty that this process would lead to a satisfactory outcome for him*. Basically, he went on, we should be able to abolish the distinction between the disabled and the able-bodied by good integration. This was the ultimate aim. Only then would we have eliminated the impression of dependence that burdened some of us.

I believe I am right in saying that *all* the speakers - ranging from "preparation for work" to "placement" of the disabled person - have followed this guideline and that there are no differences of opinion between the most highly qualified experts and the Commission of the European Communities on the "ultimate aim" to be achieved.

Mr. COPPE also said that during these three days, the Commission hoped to make further progress in the way of ideas, with your assistance; it wanted to base the guidelines of its policy on a synthesis of concrete experience. It hoped that you would contribute to this synthesis. It would not fail to study in depth and develop the conclusions you reached, in the course of its work.

Considering the co-operation we had received and the standing of the persons assembled here, continued Mr. COPPE, there could be no doubt that your work would be fruitful an would provide the Community institutions with the essential basis for the launching of an action programme at Community level.

I can already say that the material collected at this colloquium will greatly assist the Commission in preparing a practical programme of action which will be put before the Council of Ministers, since we wish, in co-operation with the Council, to work out on the political level a way of tackling the problem of rehabilitation and of promoting the employment of the disabled which is in conformity with the aims of our age.

Here again we shall have to make choices, but we will be able to make them in full knowledge of the facts, thanks to you.

However, it is now clear that it is absolutely essential for this colloquium to serve as the launching pad for the formation of a body made up of scientific and government experts, employers, workers and disabled persons to provide a permanent meeting place for all those who are today concerned with the problem of the occupational rehabilitation and employment of the disabled in our countries. This body would be an effective instrument to prepare programmes of action as they are needed, to organise exchanges of men and documentation, to disseminate information and to decide on the research to be undertaken.

At such meetings, experts from the international organisations and from other countries would certainly not be unwelcome.

It is quite clear to me that you have achieved marvellous and astonishing results in the field with which we are concerned, but it must be admitted that they are scattered. There is no doubt that if we are kept continuously informed of the best things that are being done in each of our countries, if we can exchange views on the value of or gaps in our experience, not sporadically as in the case of colloquia but in a permanent body, we shall be able to develop methods and means that will greatly improve the effectiveness of all our efforts.

I think that if we succeed in using in a co-ordinated fashion the facilities for action already existing in the Community:

- the consultative bodies between the Community institutions and both sides of industry (Standing Committee on Employment),
- the facilities of the ECSC,
- the facilities of the renovated European Social Fund,
- the facilities available to national and regional governments (Départements, Provinces, Länder),
- hospitals and rehabilitation and vocational training centres,
- the private and public bodies concerned with the problems of the disabled,
- the industrial organisations (employers associations and trade unions),

much duplication will be avoided, considerable gains will be achieved and vast possibilities of fruitful co-operation will be opened up to improve the life and future of the disabled of today and tomorrow.

It is now my pleasant duty to thank all those - rapporteurs, co-rapporteurs, chairmen of sessions - who have helped us to organise this splendid colloquium and to make it such a success.

I should like to express my particular gratitude to my Director, Dr. VIDALI, and all his team, who in an extremely short time managed to organise in quite remarkable fashion this first big Community meeting.

I should also like to thank our team of interpreters who for three days have helped us to achieve the mutual understanding so essential to the success of this great venture.

It is with great emotion that I close this Colloquium. I wanted it to be held before my departure from the European Communities not only for professional reasons but also for personal ones, whose significance many of you will be aware of.

It remains for me to wish you a good journey home and success in your work on behalf of those who have been in our minds and hearts for the past three days.

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THE REHABILITATION OF THE DISABLED

Study carried out by the Commission services on the basis of sponsored research and advice received between 1955 and 1970

A. - INTRODUCTION

All programmes in this context are subject to certain restrictions, i.e.,

- the programmes to be undertaken cannot be subordinated to financial considerations; they must conform first and foremost to requirements of solidarity and promotion, the financial expediency of which is nevertheless considerable;
- socially reintegrating disabled persons means making them independent, gaining their free and voluntary individual support, without placing them in a class apart;
- pursuing a policy of rehabilitation does not mean adding a new sphere to those connected with therapeutic training, other training, resettlement and other programmes, but the introduction of methods enabling these programmes to be effectively interlinked at the level of all the individual processes to which they refer.

Within these limits, many positive programmes may be envisaged; they must be planned and executed in such a manner as to be mutually supporting and supplementary. With this aim in view, it is a good thing to use a reference plan (on a unit basis as far as possible) capable of being added to and periodically adjusted. In its present form, therefore, the value of this study is provisional; it may be of use in the short term for interrelating the programmes envisaged by the Community and for guiding the efforts of research workers, organisations and experts associated in one way or another with these programmes.

The Commission wishes to thank all those who by their assistance in its work have indirectly contributed to this document.

B. - BASIC DEFINITIONS AND PRINCIPLES

1. Modern society responds to requirements of progress and development which have considerable repercussions at the individual level. Thus everyone is continually called upon to excel himself.

A state of adjustment exists when each individual takes part in the life and activities of his group at the cost of a tolerable effort and with mutual satisfaction. Adjustment relationships may be improved by:

- easing of tasks (technical rearrangements, better organisation);
- improvement of individual contributions and an endeavour to make better use of them;
- informatory and teaching programmes for promoting solidarity and combating arbitrary attitudes of evaluation, penalisation and exclusion adopted by groups in respect of certain categories of people (from the point of view of age, sex, origin, etc.).

2. The adjustment relationships of a person or a group with community life may be disrupted by incidents which

- eliminate the "protective conditions" and reveal a latent inadequacy, the origin of which may be physical (sickness) or vocational (a specialisation which has become obsolete), for instance as a result of termination of employment, the closing down or conversion of a firm; or else:

- directly deprive those concerned of some of their means, or even their capability of carrying on an independent existence - in the event of sickness or an accident with lasting effects.

In this way, these persons or groups are confronted by difficulties which they cannot overcome by their own resources (+).

The resultant maladjustment is an individual matter which calls for individual measures.

3. Rehabilitation is the process which eliminates a professional or social disability; it comprises:

- restorative programmes: these concern the cause of the disability, which must be identified, reduced, stabilised, corrected and, if possible, eliminated;
- preparatory programmes: these concern the available faculties which must be developed and used to compensate for the inadequate or lost faculties, by enhancing the value of the subject's skills;
- conservatory programmes: these are aimed at the lasting preservation of the result achieved.

These programmes pursue a definitive purpose. Whereas the aim of the restorative programmes is imposed by the force of circumstances, the aim of the preparatory programmes should be the subject of an express decision. This

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(+) Henceforth the expression "disability" will be used to describe the difference between the performance expected from someone engaged in a job of work or playing a social role (compulsions) and the performance he is able to give under actual working conditions (limitations); we can thus distinguish the vocational or social disability from its specific causes.

decision should be based on a functional evaluation, on forecasts as to the functional gain to be achieved - the time needed - the desirable means, and finally on an inventory of the means actually available; it will be periodically reviewed, as and when results are achieved and uncertainties lessened.

These programmes are also temporary. Often they can only be carried out in places other than those where the subject lives and works, and this involves certain dangers: the chances of success decrease as the length of this period of segregation increases. Rehabilitation is achieved by the reintegration of the subject into his own environment or into a new environment; it will be achieved by a new adjustment - not perfect, but lasting - of the subject and of the receiving environment.

These programmes must thus be coordinated.

4. The event which causes or reveals the disability (accident, sickness, dismissal from work, etc.) is experienced subjectively by the disabled person and those near to him, as

- raising doubts as to his hopes, plans and commitments (uncertainty as to personal future);
- placing him in a state of dependence.

This awareness of the disability calls for firm tackling of the problem in a manner which enables promises to be made and kept, responsibility for which rests upon:

- the subject himself: after being suitably enlightened and sustained, he must accept his condition and participate fully in decisions and actions which concern him; the family plays a decisive role in this respect;
- the "specialist teams" who are qualified to undertake the medico-surgical restorative treatment, the functional re-education and evaluation, the occupational

therapy and retraining for work and - if necessary - vocational training and guidance, the initial training for and the taking up of a new job (+); although they may concern different organisations these programmes must be continuously interlinked;

- society as a whole, which makes available the abovementioned equipment and services and supplements them with financial benefits.

These latter are intended to provide the disabled person with:

- a sufficient level of income during the process of rehabilitation;
- any necessary compensation for "loss of earnings" arising from the disability when work is resumed.

5. This tackling of the problem is at present characterised by a difference of attitudes:

- the attitude of the subject depends on his interest in work; it is influenced by the expectation of financial benefits;
- the attitude of the "specialist teams" is dictated by their own specialisation (the assignment of responsibilities does not always result in a practical sharing out of the work; it often results in more barriers than links), by material constraints and the reactions of the team to these constraints (e.g. ratio of availability of service to demands for care);
- the attitude of society may be consistent in each of the "crosswise" stages on the way to rehabilitation (provision of money, provision of services, working

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(+) We have referred here to a disability of traumatic origin - other disabilities are possible, and appropriate channels can be indicated in each case.

conditions, etc.), but it is much less so from the point of view of the synthesis of the facilities available. For instance, social security arrangements do not always encourage return to an independent life and paid work.

6. The aim will thus be to provide the necessary operational unity for each individual rehabilitation process, and therefore:

- to make it technically efficient by means of the appropriate means and know-how;
- to limit it in time, or in other words
  - to do it at the right time
  - to see that its outcome conforms to the subject's highest hopes and to common social and economic interests.

C. - COORDINATION

1. The social and vocational reintegration of the disabled is the end-product of individual, temporary and definitive processes of rehabilitation, the medical, vocational and "financial" parts of which are complex in themselves and, though often the concern of different organisations, interdependent. Besides its human and technical aspects, therefore, rehabilitation creates operational problems (coordination of numerous programmes and decisions), both as regards the conduct of each individual process and as regards its aspects which apply to the community. In this respect, we may distinguish four relatively uniform groups of disability:

a) Anomalies and complaints present at birth or since an early age;
b) Illnesses or accidents which have caused a lasting interruption of active life;
c) Minor disabilities whose cumulative effects may prejudice chances of reemployment (especially in the last third of active life);

d) Disability of retirement and old age.

It will be useful to study thoroughly the problems peculiar to them. At present it only seems possible to formulate working hypotheses on the individual and public aspects of the problem.

2. Implementation of individual coordination

The starting point of the process of rehabilitation is almost invariably a medical observation or finding (+).

Whether the fundamental observation be fortuitous, the result of a systematic programme of preventive medicine, or caused by sudden events, the doctor must be aware that action in respect of a certain or probable disability is not a matter for one man; he will thus have recourse to various specialists, not only from the therapeutic point of view but also from that of prognosis. At the same time, the organisations responsible for social services, provision of financial assistance, provision of non-medical technical services, and for return to work should be alerted; their contributions must be planned and prepared in advance, since otherwise the process of rehabilitation will be attended by uncertainties and hiatuses with two results: the congestion of services and inadequacy of the result. Team work thus appears necessary; the appointed representatives of the organisations mentioned would have to take firmly in hand the coordination of the process and to regard the duties thus assumed as part of their normal work. The important decisions as regards the

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(+) This is true even of the disabilities referred to under c). The works doctor, who knows the overall state of health of the personnel in his care, who is aware of the personnel who are being engaged and who are leaving the firm, and who is familiar with the resultant age-structure and the psycho-sociological problems involved in the firm, should be in a position to make a contribution to the arrangement of practical rehabilitation measures in the event of cessation of operations, specialisation, or conversion of the firm.

channel of rehabilitation to follow, the time-table for its implementation, the date of resumption of work, and any financial assistance needed would be taken jointly and in real time - this means that the team would have to be complete, that the doctors would have to be in a position to make reliable forecasts, and that the other members of the team would have to be vested with sufficient delegated authority by the organisations they represent.

The technical prerequisites for such cooperation are as follows:

a) The team dealing with a given subject should base its operations on a single set of clinical documentation, programmed as regards the collection of the necessary data, centralised, and accessible to all parties concerned;

b) The decision which needed to be taken should be facilitated by reference material based on clinical and social research (see para. D. 2);

c) The team work should be supported and evaluated from outside (see point 3 below).

The advantages will be: shortening of the rehabilitation process, with better results; alleviation of procedurs; and the patient's confidence.

Coordinated handling should be available primarily for accident or sickness cases affecting persons who have professional or educational work commitments. An outline is given in Appendix I.

3. Aspects affecting the community

In addition to its individual importance for the disabled person, rehabilitation is an activity that concerns the public, which contributes to the protection and proper employment of the active population. Its development depends on initiatives of general importance, undertaken by the national authorities, and specific initiatives on the part of public and private organisations. Since every large urban concentration, industrial area or economic region has its own problems, it is appropriate to consider the setting-up of "Rehabilitation Committees" consisting of representatives of the medical profession, overall coordinating organisation, bodies providing treatment and care, employment services, and employers and employees, with the following tasks:

a) to draw up a list of public and private resources available in situ, and to make an initial inventory of needs at local level. These needs cannot be expressed directly in simple figures. Allowance must be made for the number of disabled, the length of the rehabilitation process and the techniques to be used, and of the actual demand for services. In each of the categories mentioned in para. B. 1, the source of information will differ. The synthesis must be made in terms of functions to be performed and services to be rendered.

b) To propose to the public a programme of concrete action, aimed especially at sponsoring the team work described in para. C. 2, informing the public, developing sheltered work, preventing and detecting disabilities, and practically reintegrating the disabled (see Appendix II on this subject).

c) To feed back to central authorities sufficient information to carry out
  - a criticism and adaptation of methods of general application;
  - an objective assessment of medium-term needs to form a basis for national training and equipment programmes.

The prerequisites for the efficient functioning of "Local Rehabilitation Committees" may be defined as follows:

- existence of links
  - with a central body (to receive information and

documentation consistent with a clear health policy);

  - with other local committees, especially those working in neighbouring regions (collaboration with a view to joint programmes; solution of problems which go beyond local level, especially as regards the use of specialised equipment);

- genuine passong-on of the idea and the habit of "service" by doctors and social workers to the other categories, by means of an educational programme which should begin in school;

- availability of funds.

It is superfluous to discuss the advantages which may be expected of this. Neither the isolated actions of persons and centres whose specific vocation is rehabilitation, nor the too-distant actions of central government seem to be able on their own to arouse and enlist in an orderly fashion the energies necessary for a real solution of the problem in question.

4. The methods mentioned in paras. 2 and 3 are proposed by way of hypotheses, justified by the present development of theoretical and practical concepts. This development must go hand-in-hand with a change in public attitudes (transition from an attitude of segregation or indifference to an attitude of mutual aid and receptiveness) and a change as regards social security systems, with a view to guaranteeing equal chances to all disabled persons, and the replacing once and for all of the criterion of disability by that of adaptation.

D. - KNOWLEDGE

1. What matters is the knowledge and the know-how gained by the practitioner from his own experience (under valid conditions) and the information received by him (which must consist of true "units of information" which are

reliable, interlinked, and directly applicable). In this sphere, the need is thus:

- to programme observation and experimentation on the basis of a common methodology;
- to "raise" the data to a level at which they can be summarised, and to summarise them;
- to see that the verified knowledge ends up where it is of use, in the form of valid date.

These various points will be dealt with below in logical and not systematic order.

2. It is essential that knowledge be improvised in many fields, in which the research effort should be increased and coordinated. It is nevertheless necessary to lay stress on a qualitative requirement, rather than on the spheres of research, namely on enhancement of the value of clinical research. With this aim in view,

- cooperation between basic and clinical research workers working in their own field, but periodically comparing their results, can confer valuable benefits, especially in the spheres mentioned in Appendix III;
- clinics and like services should be called upon to work together on the basis of methods of examination and observation programmes jointly chosen and formulated;
- certain specialised centres treat clearly defined classes of patients (e.g., paraplegics or persons suffering from burns) and take them into care for long periods. Their small capacity is an obstacle to clinical statistics; the outcome of this is an imperfect knowledge of the pathology and therapy of the complaints mentioned. It is in cases like these that coordination (medical dossier, use of data-processing, etc) would produce the speediest benefits.

It is by stressing the methodological aspects (choice, timing and reliability of examinations) that the comparison and summarising of clinical observations will be made possible. Learned societies and post-graduate teachers have an important part to play in this sphere. They must however play that part more completely, and in particular:

- plan coordinated study courses, instead of confining themselves to the discussion of spontaneous contributions;
- increasingly implicate practitioners of the various disciplines, thereby contributing to their training.

3. The extension and coordination of clinical research should make it possible to assist all centres and services to attain a comparable level of efficiency. With this aim in view, their work must be given common practical terms of reference, not with a view to limiting the action of the doctors and the specialist centres, but in order to provide models and to create a common language which are both still lacking and which are prerequisites of progress. These common terms of reference seem indispensable in the following fields:

a) The collection at the right moment of essential data regarding each case treated. In para. C. 2, a "programmed clinical documentation" was mentioned as a tool of team work. Standard clinical observation programmes, to be compiled for the various lesions and illnesses, would have the following advantages:
   - a moral obligation to carry out reliable examinations at the right time;
   - a large number of complete and reliable dossiers, utilisable for broad clinical statistics;
   - ease of organisation of investigation or research campaigns into definite problems (evaluation of a new therapy, for instance).

b) In order to become independent, the disabled person should be able to cope with an essential minimum of exigencies of personal life (e.g. dress and feed himself, and attend to bodily needs), social life (adaptation to standard conditions of housing and transport), working life (necessary actions); they are technical in nature (e.g. arrangement of a door handle) and also aesthetic. The ability to cope with these requirements is achieved by compensatory training (by diverting and developing certain faculties still present), and if necessary by the addition of a prosthesis, by the use of auxiliary means. Whereas the requirements mentioned change, the choices of functional compensation are to a great extent irrevocable, and should be based on common criteria of utility. These latter could serve as a guide not only in reconstructive surgery, in functional re-education and when fitting is carried out, but also as regards everything connected with the standardisation of objects and services essential to daily life.

c) In functional re-education and retraining for work, the specific performances demanded of the patient are gradually increased. The optimum rate of progress depends on the state of the organs made use of, but also on the state of the regulatory systems listed in Appendix III. These latter are of particular consequence in the case of lesions of the nervous system, but no objective criteria of assessment are available. The problem is twofold:

  - to have at one's disposal simple and meaningful methods of functional diagnosis;
  - to have at one's disposal scales of difficulty of tasks which are not analytical but which embrace all the patient's sensory and motive faculties and those of integration and endurance - which, in fact, relate to real jobs of work.

d) Finally, it is necessary to formulate common criteria of skill for use in connection with vocational guidance, with recruitment tests and with assessment in the course of supervision, bearing in mind:

- the vocational qualifications indicated by generel and local trends of the labour market;
- the economic activities chosen for orienting sheltered work;
- the jobs which may be best suited to the different kinds of disabilities.

Care should be taken, however, not to consider only the specific disability, but also minor disabilities which have accumulated during working life.

4. The dissemination of knowledge should take account of the special requirements of the transmission of ideas and savoir faire.

a) As regards the ideas to be transmitted, the need for a form that takes account of the needs of the practitioner must be stressed. A piece of information is useless unless accompanied by directions enabling the reader to link it with his own knowledge and to make use of it at technical level. Then again, it is essential to achieve uniformity of language, and this cannot be done without much effort as regards classification and terminology.

b) "Savoir faire" cannot be acquired without proper training. With this aim in view, it would be advisable to pay particular attention to the Institutes, Centres and Services which are known for their:

- good average clinical results;
- active and very open cooperation with similar centres, especially in the field of methodology;
- good facilities and attitudes for reception.

E. - DEVELOPMENT AND TECHNICAL APPLICATIONS

The proper organisation of health services requires certain technical means of prevention, diagnosis and therapy to be made available to one and all speedily (that is to say, as soon as the methods and their sphere of application have been specified) and on equitable terms. Failing this, the "ideas" and "savoir faire" acquired by clinical research are in considerable danger of remaining unused. Prostheses,(+) especially those intended for amputees, are a good example of the problems arising in this field.

An amputation prosthesis is clearly distinguishable from any other manufactured applicance, since its purpose is to replace a tool which is generally perfect: the lost member. The only criterion of its value is use: actual, full-time use for tasks as diverse as possible, starting with those which are most frequent. For this reason, we are far from having solved the essential problems; substantial progress is desirable at practical lecel as regards adaptation, and at technical level as regards performance.

Adaptation: As an aim to be achieved, the proper adaptation of a prosthesis calls for:

a) knowledge of the patient, his activities and hopes;
b) whenever amputation is a planned act, simultaneity between the study of the operative requirements (level and method of amputation) and the fitting prescription;
c) individual adaptation and fitting of the prosthesis by a competent technician at the appropriate time;
d) basic training in its use; periodic checking.

The current tendency is to shorten the time between amputation and fitting, to use adjustable prostheses until such time as the stump has become stabilised, and to use trial fittings as a means of deciding on the definitive characteristics of the prosthesis.

(+) appliances intended to compensate for the functional or anatomical loss of an organ, a member or part of a member.

Performance: The prosthesis must perform three functions: a passive function of replacement for purposes of appearance and equilibrium (it should be noted in this context that the distribution of the masses of the body plays an overall static and dynamic role); the completed movement, with all ist constituents (speed and precision, finesse and strength, dependability and ease of control); the feeding-back of information as regards the position of the artificial member, the movement executed, and the obstacles which it encounters.

At development level, practical progress may be expected from surgery which is more concentrated on the function and the better integration of the re-educator and fitter into the medical team. Then again, technical progress is necessary to ensure the functions just mentioned. Technical progress may be guided by "common utility criteria" (cf. para. D., 3c); as soon as advances are made, they should become available.(+)

Artisanal methods are necessary for the construction of prostheses (working of wood, leather, metal, rubber and plastics), and requirements as regards quality and speed of production are increasing; moreover, prostheses increasingly tend to include special devices which depend on modern materials and advanced techniques (fluid mechanics, electronics, etc). Research must thus be followed by the manufacture in sufficiently large numbers and the distribution of prefabricated and adaptable parts and mechanisms. A priori,

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(+) Research is obviously the appropriate instrument for accelerating technical progress. Although medical (and especially clinical) research remains very necessary in this sphere, it is also necessary to promote every activity which can facilitate the transition from "biophysics" - a fundamental science - to "bio-medical engineering", a subject still insufficiently developed in Europe.

the following stages will have to be gone through:

a) protection of inventor's rights;
b) provision of information to manufacturers and granting of licenses;
c) manufacture and sale;
d) inspection of the product from point of view of:
  - proposed operating conditions,
  - user's needs,
  - any international standards,
  - standards of the organisation taking care of the patient;
e) guarantee of sufficient technical assistance as regards:
  - power supply (if applicable),
  - spares and repairs.

Thus whilst it seems natural to give all amputees benefits in keeping with the general level of technical development, and whilst one sometimes sees prostheses which are technically very advanced, the transition from a good prototype to its general use remains difficult.

The difficulties come from various directions:

a) The order for every appliance originates in a prescription and the prescribing doctor is not always well informed;

b) Markets are small; the segregation of national markets is caused not only by the continued existence of customs and tax barriers, but also and above all by the rules of the organisations responsible for the care of the patients, which purchase a large proportion of the output;

c) Prostheses and the habits to which they give rise last for a long time; consequently old and new prostheses exist side by side, and too many parts serving a similar purpose but incompatible with one another from the point of view of assembly, are sold simultaneously.

d) Finally, there is no methodical a posteriori evaluation of the advantages actually derived by the user from the prosthesis.

If a solution is to be found, continuous effort will be needed, aimed especially at progress along the following lines:

- development and practical promotion of "modular" or multi-purpose prostheses, consisting of standardised parts;
- exemption from customs duties and taxation of prefabricated parts of prostheses constructed in member countries of the Community and in countries willing to grant reciprocity;
- harmonisations of approval criteria applied by the organisations responsible for the care of the patients;
- progressive standardisation of levels and conditions of training of technicians and re-educators; harmonisation of conditions of qualification and exercise of their professions;
- common quality control carried out by qualified bodies on commercial samples.

The foregoing remarks about the fitting of amputees with prostheses also apply to prosthetic appliances as a whole (cf. note on page).

Joint action in this sphere along the lines indicated may provide the necessary experience for the development as a whole of the technical methods necessary for prevention, diagnosis and therapy.

APPENDIX I

Example of implementation of individual coordination

Whenever there is an interruption of activity which may last longer than a certain time (e.g. 90 days), the case should be discussed by a team consisting of:

- the doctor responsible for the receiving clinic and, if possible, the family doctor;
- the works or school doctor;
- the representatives of the organisations responsible for the financial and compensation aspects;
- the social worker;

a meeting of these persons should be arranged as soon as an initial prognosis is possible.

After being informed of the condition of the subject and the functional prognosis, the team should:

- create a single, complete original file, to be added to periodically;
- specify the therapeutic and administrative measures to be taken (quality and time-table), discuss these with the person concerned, arrange them and establish contacts with the other services and organisations whose participation is considered necessary (Rehabilitation Centre, Employment Exchange and its specialised services, etc.);
- make a periodic survey of progress achieved, and progressively adapt the programme; suggest the date of resumption of work and specify subsequent adaptation checks.

The aim is to ensure that by keeping one another informed and taking joint decisions:

- the necessary examinations will be effected at the proper time and by valid methods;
- services are rendered at the proper time and continuously;
- any (properly prepared) change of work will have the effect of a vocational promotion and not a demotion;

- each party concerned has full information about the results of his contribution and will gradually adjust his methods.

APPENDIX II

General outline of a programme of action at local level

1. Encourage the individual handling of rehabilitation and the team work described in para. C 2 and Appendix I and, on the basis of the experience thus gained, the best utilisation of resources in staff and equipment.

2. Keep the public informed, with a view:

    - to instigating and suitably orienting individual initiatives (private initiatives especially) which can contribute to the prevention of disabilities and the reintegration of the disabled;
    - encouraging rehabilitated disabled persons to seek work, and prompting offers of employment which they can accept.

3. Foster sheltered employment. This latter depends on a choice of work connected with production or the rendering of services which can be carried out by sheltered workshops - a choice which should reflect regional or local economic conditions. Heads of firms could make a very valuable contribution.

4. Reduce the overall number of disabled. Needless to say the spread of efficient preventive medicine would considerably reduce the number and seriousness of the disabilities which occur, and limit the tasks of rehabilitation to the essential. Meanwhile we can:

    - improve existing contacts between the various current forms of preventive medicine (school and industrial medical services, etc.) and therapeutic medicine;

- encourage systematic programmes of preventive medicine, especially as regards prenatal and natal disabilities, with a view to having the necessary therapeutic action taken at the proper time, advising parents, calculating the number of disabled children in terms of their therapeutic, educational vocational guidance and training requirements, and arranging the necessary action.

5. Encourage practical steps which facilitate the social integration of the disabled, especially as regards:

- children (classes for mentally-retarded children)
- isolated disabled persons and old persons (housing, assistance)
- families containing seriously disabled persons (specially adapted housing)
- the disabled generally (arrangements giving them access to public transport and enabling them to use it).

APPENDIX III

Fields of research in which interdisciplinary cooperation is especially desirable

1. - Modifications undergone by the major organic systems during the evolutive ages (in particular childhood and old age);

   - the factors which may affect them (metabolic or traumatic changes, infections and poisonings, diet, inactivity or lack of stresses) and the way in which they act.

   - the pathology of these ages, and especially the chronic complaints responsible for frequent, serious and irreversible disability.

2. - Traumatic lesions, and especially those requiring long-term treatment with uncertain results (cranial lesions, lesions of the vertebral column, burns, etc.).

3. - Regulatory mechanisms which are disturbed by the lesion or the illness and affect recovery, basic training, retraining, and especially:

   - those which act at tissue level during repair of the lesions,
   - those which control metabolic and energy exchanges,
   - those which control the adaptation of the organism to its biophysical sphere under different conditions of outside stress, posture, movement and activity,
   - those which are involved in physical and affective reactions and which control psycho-sensorial and psycho-motor faculties.

Papers prepared by delegates for presentation at the final session

H. TRACHTE

Mr. Chairman, Ladies and Gentlemen,

I should like, if I may, to make a few comments on the paper given yesterday morning by Mr. VELDKAMP. Mr. VELDKAMP criticised the practice of analysing disability in causal terms, which has the effect, among other things, of distinguishing victims of industrial accidents or occupational diseases from other disabled persons. He advocated the abandonment of the causality principle in favour of the so-called finality principle, on the ground that what matters for a disabled person is not the cause but solely the fact of his disability. This last proposition is undoubtedly valid, and the same point has also been made by other contributors to this symposium. I would question, however, whether the idea of finality in the rehabilitation process precludes the application of the causality principle in the field of statutory accident insurance. Here, as in welfare for the war-disabled, the causality principle does not run counter to or conflict with the concept that all disabled persons are entitled to the best possible rehabilitation that can be devised, The view that it does is based on the mistaken assumption that it is the finality principle which is responsible for all disabled persons being given the same rehabilitation treatment, and that this and the causality principle are incompatible. Neither conclusion stands up to critical examination. The right to equally good rehabilitation services which by common consent is enjoyed by all disabled persons can only be deduced, insofar as it has not already been enacted by legislation, from the principle that all men should be treated equally, which in turn is a basic human right. Compared with this, the question of whether something is final or causal constitutes no legal grounds on which claims to benefits can be founded.

Why, then, has the causality principle been called in question? careful analysis reveals a hidden implication in some quarters that the rehabilitation treatment provided for some causes of disability is better, prompter or more generous than for others. If this was the case, it could hardly rank as a serious objection to benefits being determined by reference to causal factors. We could only welcome it if all disabled persons received whichever rehabilitation treatment we consider necessary for the particular category of disability under our care. There is certainly no reason why accident insurance should plead guilty to a charge of manifestly distinguishing between finality- and causality-oriented types of rehabilitation, for such over-simplification misses the real point at issue. In fact, Ladies and Gentlemen, causality in accident insurance is used for quite other purposes than to determine the scale of rehabilitation benefits. Its real function - as in law generally - is rather that of logical classification. We need it because we consider it reasonable that compensation for industrial accidents and occupational diseases should, as in the case of West Germany, be borne by the employer. Employers are thus relieved of the necessity of meeting individual claims from their employees. At the same time, they have a material incentive for effective prevention, and so further one objective of accident insurance which must be given priority over all others. Finally, causality is also invoked in respect of pension claims, though this has nothing to do with rehabilitation, since rehabilitation takes precedence over pensions. This raises the question whether physical disablement through accident or war should ever be indemnified by anything but disability pensions. The answer in my opinion ought to be unreservedly in the affirmative. But since, as I have said, this is not a question which concerns rehabilitation, I do not propose here to set out the argument in detail.

Causality is thus no obstacle to rehabilitation, whereas finality on its own is not a sufficient cause for all disabled persons being entitled to equal treatment. I hope I have succeeded in demonstrating that causality - even where rehabilitation is treated in terms of finality - can well retain its place and importance in social security, provided that the principle of selective social insurance is recognised. Whether and, if so, to what extent causality principles cease to be necessary in a perfect welfare state is a question into which I do not wish to enter, if only because its premise - that a welfare state is desirable - is not up for discussion.

Let me, in conclusion, draw your attention to one advantage of accident insurance which the growing achievements that are being seen in the field of rehabilitation help to underline. This is that the responsibility borne by the insurer at all stages of the rehabilitation process is undivided. In turn, this makes for continuity, on which so much of the effectiveness of rehabilitation depends.

Moreover, the accident insurer, in the interest of prevention, undertakes statistical analyses of accidents and their causes, which again makes it easier for those engaged in the work of rehabilitation, in the light of the experiences gained, to resettle the disabled wherever possible in accident-free jobs. Thus the wide-ranging circle of accident insurance services - beginning with the organisation of an effective first aid system and ending, again with due regard for preventive considerations, in reintegration into employment and continuing after-care - is finally completed.

J. TEJMAR

The American sociologist Kurt Lewin once coined the expression "A good theory is the best practice". It seems to me that a proper definition of many of the ideas which have been put forward here will demand not only practical application but also a great deal of effort. Disabling anomalies occur in 7% of all children after the age of 6 (cf. H. Nishimura, Chemistry and prevention of congenital anomalies, Ch.C. Thomas, Springfield, Ill. 1964), while according to V. Apgar (Congenital Anomalies, Bull. Material and Infant Health, 7, 1960, No. 2, p. 18) partly concealed and clinically inert anomalies are present in almost half the world s population. This excludes, of course, disabilities due to accidents, sickness and physiological ageing. Complete social rehabilitation is an idea which has to be defined extremely broadly. There are known cases of young women working in a fish canning factory who were socially ostracised on account of their persistent smell, and at SAARBERG AG we are now intensively looking for more effective hand cleaners because of the socially damaging effect of permanent dirt on our workers' hands. Times do change. Or is it not the case that we elderly sclerotics are becoming disabled too? Anyhow, it is meaningless to talk of any disability whatever unless it is related to a specific standard.

The point I should like to make is not that serious disablement should be taken lightly, but that the sliding scale of disablement, which runs counter to a sliding scale of standards, knows no rigid line, and that "completely normal" people and their disabled counterparts do not confront each other in two closed and homogeneous groups. What is most important, however, is whether disablement keeps pace with adaptability, whether it can also be gauged in advance, or whether it strikes dramatically or by stealth. This poses a real dilemma: far from being trained to embrace mobility, or any kind of change, we are conditioned to banish it from our modes of conduct. The best worker according to some is he who eventually retires from the same occupation and the same firm as where he had started his apprenticeship. Given such ideals, how should a heavily disabled person feel if he has got to find another job?

Altogether, our efforts on behalf of the disabled, as of anybody else, must throughout be focused on their self-consciousness, Our job is to open as many doors for them as humanly possible, without ever or anywhere pulling them by a string. What is wrong, after all, if some disabled people merely want to enjoy their pension? Such an ambition is not dishonourable, any more than it ought to be dishonourable to have it frankly reported. No doubt, there is a majority even among the heavily disabled who are anxious to excel in order to satisfy their equally natural self-respect. Our task is not to judge but to help. In doing so, let us be guided by the maxim "In dubiis libertas" ("Give always the benefit of the doubt").

L. PIERQUIN

Those attending these discussions will doubtless have observed that the papers on the vocational rehabilitation of the disabled were preceded by a study of the medical aspect of rehabilitation, that is to say functional rehabilitation and, to some extent, vocational rehabilitation. This mixture is not fortuitous, but reflects the deliberate intention of the organisers of this meeting to combine the medical and vocational aspects of rehabilitation, and to prove that they are intermingled and must of necessity be considered as a whole.

As the head of a Rehabilitation Institution which consists of a medical centre and a vocational centre, I should like to tell you about my task and my hopes.

I have the daily task of gathering together the vocational technicians and doctors in a single team around the disabled person. They experience difficulty in getting together, because they have not the same training, the same occupation, or the same attitude of mind, The doctors tend to abandon the disabled person to his fate when they consider his complaint cured; most of them are not really interested in the social and vocational reintegration of their sick and injured patients. On the other hand, employment specialists too often regard the physically disabled person as a man like any other, and subject him unduly to the constraints of work, disregarding the human peculiarities of his condition.

What I should like to see - and this is my hope - would be "rehabilitation, one and indivisible", with medical and vocational rehabilitation no longer sharply divided but intermingled at all times; the doctors taking an interest in their patients from beginning to end; and with sociological and vocational problems being considered as soon as the complaint begins.

We in our country are making an effort along these lines, by trying to arrange meetings of the members of the Société Nationale de Réadaptation Médicale with those of the Société de Réadaptation Professionnelle with a view to studying the concrete problems of rehabilitation.

These meetings will certainly be beneficial, and I should like to quote the example of orthopaedic and prosthetic equipment, a difficult matter which concerns the rehabilitation of a large number of persons suffering from paralysis and from loss of limbs.

Our backwardness in this matter is the result of the fragmentation of the work, which has too often been done on a single-nation basis. The technicians have studied only their techniques, the doctors their patients, the re-educators those who came to them to move their arms and legs. The results have been mediocre.

If the science of equipment is to develop and really to be applied to human needs, technicians, doctors and re-educators will have to gather together around the disabled person who is, after all, the judge of the matter. Moreover, in view of the difficulty of the problem, there will have to be an increase in international cooperation on this subject, and European research and educationed bodies will have to be set up.

G.G. KUHN

For many physically disabled persons optimum orthopaedic and technical care is a very important prerequisite of successful vocational reintegration. It is essential that common efforts be nade at European level with the following aims in view:

1) The collection and dissemination of knowledge and experience in the sphere of orthopaedic technology.
2) The coordination of research so as to make better use of available resources and opportunities.
3) The standardisation of training of orthopaedic technicians and its adaptation to technological development.
4) To enable orthopaedic mechanics to be given engineering training leading to a university-level qualification, so as to make available trained technical staff for research and training, and to provide career prospects for orthopaedic mechanics.

These tasks could best be carried out by a European Centre for Technical Orthopaedic Rehabilitation, which should deal with:

1) Technical orthopaedic documentation (collection, literature, museum, educational aids).
2) Technical orthopaedic research (information, coordination, execution).
3) The training of master orthopaedic mechanics as Technopaedic Engineers.
4) Further education of all members of the technical orthopaedic rehabilitation team (especially orthopaedic mechanics, doctors, remedial gymnasts, occupational therapists, psychologists and social workers) in the field of technical orthopaedics.
5) Information by means of periodic supranational litera-

ture and research reports.

This could considerably improve the position as regards technical orthopaedics, which at present is certainly the weakest point in rehabilitation as a whole.

G. FAJAL

Many speakers have spoken about the resettlement and re-employment of the disabled. It is heartening to feel so much interest being shown in this problem.

Nevertheless, if the disabled are to be properly resettled they must first have all possible assistance in rehabilitation and have recovered their physical and psychic faculties altogether, or as far as possible.

This is not yet the case, particularly as regards equipment and subsequent rehabilitation.

The national structures cannot solve all the medical and technical problems of rehabilitation and fitting; there is an urgent need for European bodies specialising in research, documentation and teaching, and supported by the European organisations.

At the cultural or administrative level, European bodies have been set up and have worked efficiently. Perhaps it is necessary to go one step further and to set up technical bodies for training officials in equipment and rehabilitation who have European ideas, methods and minds. A European Centre of Orthopaedic Technology and Rehabilitation would enable specialists of the various countries and disabled persons to meet and train one another. Rehabilitation would then have done its utmost, and one could then look forward to efficient and humane social and vocational reintegration.

N.E. COOPER

May I present one or two ideas or suggestions for possible future action in the field of vocational rehabilitation.

With regard to placement and rehabilitation counselling of the disabled, I think it is true to say that (apart from the USA where rehabilitation counsellor training is given in many universities up to Master's level) in most countries the training of staff engaged in this vital work is usually carried out on an on-service or an on-the-job basis. I suggest that there may be a good case for prodiving a specific career opportunity for placement and rehabilitation counsellors in Europe and other regions, at least up to diploma and possibly degree level, embracing such subjects as psychological testing, ergonomics, labour market conditions, etc. This would undoubtedly put placement and counselling work on a higher professional level to the advantage not only of the staff and service concerned, but also to employers, and most important of all, the disabled themselves.

Secondly, there would appear to be a need for the rationalisation of training methods for disabled persons. In some cases, courses are based on out-dated apprenticeship schemes and could well be streamlined and shortened in length. Moreover the aim should be to think in terms of producing a more adaptable worker to meet the requirements of industrialisation and automation.

Thirdly, I would suggest that new thinking needs to be applied to sheltered employment too often, we regard this as the second best avenue of resettlement, as a costly venture that requires large financial subsidies. And yet this need not be the case. For example, an 120 sponsored sheltered workshop in Ethiopia employing 200 seriously disabled persons is making an annual profit of $ 250.000. Wages are higher than the local average, training of workers was accomplished in weeks rather than months. Perhaps, the ideas which have gone into this project would have meaningful application to sheltered workshop programmes in developed countries.

Time does not permit a detailed description, but the ILO will be pleased to provide further information of this project and other aspects of its vocational rehabilitation programme to individuals and all organisations working in this field.

Finally, may I take this opportunity of saying how much I have appreciated attending this excellent symposium and the generous hospitality provided. I am sure we shall leave Luxembourg with very happy memories of a successful and fruitful meeting and with new ideas and fresh enthusiasm for our work on behalf of the disabled.

N. STOFFEL

General considerations

Casting a backward glance over the ideas and suggestions put forward at this symposium, I cannot help feeling that the balance has been clearly tilted in favour of the physically disabled.

Yet there are also those who are psychologically and mentally disabled. In view of the overriding emphasis which has been placed here on the physically disabled or injured, I wonder whether the Community, at a future symposium, might not be able to concentrate attention on the aid to be given to the psychologically and mentally disabled, or to submit proposals on this matter to the Council of Ministers.

SOCIAL WORKERS

A group of social workers working in industry held a meeting on 25th May 1971 on:

Practical problems encountered in resettling disabled workers in a working environment

The aim of the meeting was to study ways of giving greater effect to the resettlement procedure.

The meeting

I. took note

1) of the slow pace at which resettlement files were compiled and studied

2) the lack of coordination between

A. the bodies concerned in the resettlement process:

a) treatment centre

b) care organisations

c) technical bodies: medical
psychotechnical
administrative

B. social workers involved in the same resettlement process

doctors
psychotechnicians
vocational counsellors
social assistants

3) lack of follow-up service

Follow-up given:

on the one hand, at the level of the Administration
on the other hand, at the level of the disabled worker following a resettlement decision, whatever the origin, for each of the countries concerned (success or failure)

II. urged the following measures:

1) training: proposals have been put forward to provide students of medicine and paramedical disciplines with specific training in rehabilitation during their studies. Social workers urge that their training should also include courses in this subject.

2) training and information should be given to all personnel working in the field of resettlement

3) work as a team

4) organisation of a team meeting which would bring together

social workers in industry
works doctors employed by companies or jointly by several companies
administrative personnel

at European Community level.

We have pointed out that we are prepared to work at the regional and national level in our various countries in order to prepare a symposium to discuss this problem.

N.B. The French workers draw attention to the fact that the legislation of their country concerning resettlement is quite clear in its terms but its application leaves much to be desired.

Categories of social workers represented

GERMANY:	vocational counsellors.
BELGIUM:	social assistants employed by private organisations.
FRANCE:	vocational counsellors. social assistants employed by the social security funds. social assistants employed by departmental administrations (cf. county councils). social assistants employed by organisations for the promotion of health and welfare. social assistants employed by rehabilitation centres. social assistants employed by private associations.
LUXEMBOURG:	social assistants employed by private associations.

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